# Appendix

## Prevention & Early Intervention Stakeholder Meetings

**PEI "101"**
- Tuesday, May 6th, 2008: 5:00 p.m. to 7:00 p.m., Simpkins Swim Center, 17th Avenue, Capitola
- Friday, May 9th, 2008: 9:30 a.m. to 11:30 a.m., 1432 Freedom Boulevard, Watsonville

**First PEI meetings by age group**
- 0-25: Monday, June 2nd, 2008: 10:00 a.m. to 12:00 p.m., Aptos Park, 100 Aptos Creek Road, Aptos
- 60+: Thursday, June 5th, 4:00 p.m. to 6:00 p.m., 1430 Freedom Blvd, Room 8, Watsonville
- 26-59: Friday, June 6th, 2008, 9:30 a.m. to 11:30 a.m., 1080 Emeline Ave, large Aud, Santa Cruz

**ASR Presentation Meetings (PEI Data Feedback)**
- Tuesday, June 24th, 6:00 p.m. – 8:00 p.m., Simpkins, 979 17th Avenue, Santa Cruz
- Friday, June 27th, 9:30 a.m. - 11:30 a.m., 1432 Freedom Blvd./9 Crestview, Watsonville

**Prevention & Early Intervention planning meetings/presentations**:
- **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m., 1080 Emeline Avenue, Santa Cruz. "Trauma-Informed Services," by Gabriella Grant and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
- **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m., 1080 Emeline Avenue, Santa Cruz. "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness shared their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson, John Wright, and Kate Venturini.
- **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m., at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville. Topic: "Best Practices in Working With Stressed Families." Rivka Greenberg, Ph.D.

**Workgroup Meetings**
**0-5**: Mondays from 9:30 a.m. to 11:30 a.m.
    July 7: United Way, 1220 C 41st Avenue, Capitola
    July 21: United Way, 1220 C 41st Avenue, Capitola
    August 4: Career Center, 18 W. Beach Street, Watsonville
    August 18: United Way, 1220 C 41st Avenue, Capitola
    September 15: United Way, 1220 C 41st Avenue, Capitola
    September 29: Career Center, 18 W. Beach Street, Watsonville
**6-12**: Mondays from 10 a.m. to 12:00 p.m.
    June 30: County Office of Education, 809 Bay Avenue, Capitola
    July 14: County Office of Education, 809 Bay Avenue, Capitola
    July 28: "The Towers", 294 Green Valley Rd, Watsonville
    August 11: Mountain Community Resource Center, 6134 Hwy 9, Felton
    August 25: United Way, 1220 C 41st Avenue, Capitola

September 8: United Way, 1220 C 41st Avenue, Capitola
September 22: United Way, 1220 C 41st Avenue, Capitola

**13-17**: Wednesdays from 10:00 a.m. to 12 p.m.
July 2:  County Office of Education, 809 Bay Avenue, Capitola
July 16: County Office of Education, 809 Bay Avenue, Capitola
July 30: Career Center, 18 W. Beach Street, Watsonville
August 13: HSA Small Auditorium, 1080 Emeline Avenue, Santa Cruz
August 27: United Way, 1220 C 41st Avenue, Capitola
September 10:  Career Center, 18 W. Beach Street, Watsonville
September 24: United Way, 1220 C 41st Avenue, Capitola

**18-25**: Wednesdays from 10:00 a.m. to 12:00 p.m.
July 9:  Santa Cruz Mental Health Services, 1400 Emeline, Santa Cruz
July 23: County Office of Education, 809 Bay Avenue, Capitola
August 6: Career Center, 18 W. Beach Street, Watsonville
August 20: MHCAN, 1051 Cayuga Street, Santa Cruz
September 3: MHCAN, 1051 Cayuga Street, Santa Cruz
September 17: Career Center, 18 W. Beach Street, Watsonville

**26-59**: Fridays from 9:30 a.m. to 11:30 a.m.
July 11: Vets Memorial Bldg, 846 Front St, Santa Cruz
July 25:  1432 Freedom Blvd./9 Crestview, Watsonville
August 8: Community Counseling Center, 195 Harvey West, Santa Cruz
August 22: United Way, 1220 C 41st Avenue, Capitola
September 5: Career Center, 18 W. Beach Street, Watsonville
September 19: Diversity Center, 1117 Soquel Avenue, Santa Cruz

**60+**: Tuesdays from 9:30 a.m. to 11:30 a.m.
July 1:  Family Services, 104 Walnut Avenue, Santa Cruz
July 15: Family Services, 104 Walnut Avenue, Santa Cruz
July 29: Career Center, 18 W. Beach Street, Watsonville
August 12: Family Services, 104 Walnut Avenue, Santa Cruz
August 26: Family Services, 104 Walnut Avenue, Santa Cruz
September 9: Family Services, 104 Walnut Avenue, Santa Cruz

**Key Informant Interviews**
September 23, 2008 Manny Solano, Deputy Police Chief, Watsonville Police Department
October 7, 2008 Dorian Seamster, MD, Health Improvement Partnership of Santa Cruz.

**Focus Groups**:
Parents (English): Tuesday, 10/7/08 6:00 p.m. to 8:00 p.m.
Parents (Spanish): Tuesday, 10/2/08, 5:30 p.m. to 7:30 p.m.
Consumers (North County): Friday, 10/3/08, 11:00 a.m. to 1:00 p.m.
Consumers (South County): Thursday, 10/16/08, 10 a.m. to 2 p.m.
Seniors: Monday 10/6/08, 10:00 a.m. to 11:30 a.m.
Youth: Thursday, 10/16/08, 4:00 p.m. to 6:00 p.m., United Way
Transition Age Youth: Monday, 4:00 p.m. to 6:00 p.m., 10/20/08
Veterans/Veterans Advocates: Wednesday, 6:00 p.m. to 8:00 p.m., 12/10/09

**Final Workgroup meetings**:
Thursday, 1/8/09, 7:00 p.m. to 9:00 p.m., Simpkins Swim Center, 17th Avenue, Capitola
Friday, 1/9/09, 9:00 a.m. to 11:00 a.m., 1432 Freedom Boulevard, Watsonville

# **Work Group Meeting Notes**

**Mental Health Services Act:  Prevention & Early Intervention**
**Workgroup: Ages 0 - 5**
**7/7/08 Meeting Notes**

1. Introductions
2. Review of workgroup guidelines and rules
   a. We are to create and foster an integrated system
   b. The state has mandated that we use the Logic Model (will need to document that we are doing this and the State will evaluate us).
   c. Values and Guiding Principles
      i. Transformational programs and actions
      ii. Leveraging resources
      iii. Stigma and discrimination
      iv. Recognition of early signs
      v. Integrated and coordinated systems
      vi. Outcomes and effectiveness
      vii. Optimal point of investment
      viii. User friendly plans
      ix. Non-traditional settings.
3. The group will need to review its decision making model; we will try for consensus, and if unable to reach consensus use a majority vote to decide our recommendation.  The group needs to decide who can vote on the final decisions made to the Steering Committee
4. Workgroup member's & agendas
   a. Jerry Solomon, Facilitator, Psychologist & MFT
   b. Erika Hearon (Community Bridges) Main goal is community-based prevention; agenda is to potentially get funding, and for collaborating with others so that there are more services. Looking at family based approach that addresses all members of the family in prevention.
   c. Dane Cervine (Santa Cruz County, Chief of Children's Mental Health Services, member of MHSA Steering Committee) as part of the CSS planning, there was data that showed that in the children's MH world there was intensive services for teenagers and few services for kids 0-5. To link the early findings in CSS and apply them to PEI to carry over some consistent themes where they merge. Unsure whether the County will seek funding (probably more minor role).
   d. Wilma Gold (Outgoing chair for Childcare Planning Council of SC County, Member of COPA), goal is to identify issues within the county and be strategic about how to bring people power to address these issues. Not interested in funding, but in bringing knowledge back.
   e. Deborah Helms (rep. Cabrillo College, overseeing the foster and kinship care education care program, the options for recovery program, and special ed training for adoptive parents programs) MFT. Interested in getting prevention and early intervention to very young children and more services that have to do with family relationships. Not interested in funding.
   f. Shawn Henson (Headstart, coordinating the mental health services in Family Services) new to county and surprised how few services there are for this age

group. Trying to do some internal things ourselves, starting out a program for violence prevention. Open to funding.

g. Cathy Simmons (County of Santa Cruz, Program Supervisor with Children's Mental Health) in my practical experience working with children there is high level of need to screen younger children to prevent deficits further on in their life. Would like to see more services addressed towards those that have in utero substance exposure.

h. Ellen Timberlake (County of Santa Cruz, Deputy Dir. of Human Services Dept.) member of the Steering Committee for MHSA, asked to represent public social services in the county. And a personal passion for the importance of prevention and early intervention. The more this can happen the less likely people in our community will need to require our services so we have a big investment to ensure that we get dollars like this and leverage them in the most effective way to provide more services. Do not think our department is interested in applying for funding, not directly. Our interest is to ensure that needs of our clients are addressed. We are interested in outcomes as a service provider, and that during this process recommendations for improvement don't get lost. (Will provide a consolidated view of the mental health early intervention prevention related recommendations.)

i. Susan True (Executive Director First 5) primary agenda is to try and have some kind of discipline around this process so that whatever we do it is good with the limited resources we will have. Not necessarily interested in funding but be part of the planning working together. On the MHSA Steering Committee

j. Deborah Vitullo (Santa Cruz Community Counseling Center, Clinical Supervisor) it is very difficult to diagnose kids 0-3 and working with parents where in many cases one of them has a mental illness. Would like to see funding address services to this group. Would like to get some of the funds.

k. Laura Segura (Women's Crisis Center)

5. Planning Process
   a. Next step, pick a priority population
      i. Children/Youth in stressed families
      ii. Children/Youth at risk of school failure
      iii. Children/Youth at risk of juvenile justice involvement
      iv. Trauma exposed
      v. Experience onset of serious mental illness
   b. State will do own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
   c. Steering Committee will set funding percentage
   d. Program/s must be evidenced based with an evaluation component built in
   e. Need representation from stakeholders, as identified by the State
   f. Identify missing stakeholders
      i. Need Latino outreach
      ii. African-American community outreach

6. Priority populations, per the DMH, to focus on in this workgroup
   a. Trauma exposed
   b. Individuals experiencing the onset of a serious mental illness

      c.  Children/Youth in stressed families

      d.  Children/Youth at risk for school failure

      e.  Children/Youth at risk of experiencing criminal juvenile justice involvement

      f.  Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.

7. Workgroup decisions to be made:

      a.  Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.

      b.  Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.

           i.    Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.

          ii.    Education

        iii.    Consumers and/or their families

        iv.    Providers

          v.    Health organizations

        vi.    Social Services

      vii.    Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).

     viii.    Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media

8. Review of MHSA PEI values and guiding principles.  All in attendance stated that they were aligned with these values and principles.

      a.  Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.

           i.    Leveraging resources

          ii.    Stigma and discrimination reduction

        iii.    Recognition of early signs

        iv.    Integrated and coordinated systems

          v.    Outcomes and effectiveness

        vi.    Optimal point of investment

        ix.    User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

**Next meeting**:  July 21: United Way, 1220 C 41st Avenue, Capitola

<u>**Mental Health Services Act:  Prevention & Early Intervention**</u>
**Work Group: Ages 0-5**
**July 21, 2008 meeting notes**


Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Dane Cervine, Erika Hearon, Deutron Kebebew, Cathy Simmons, Sherra Clinton (for Ellen Timberlake), Susan True, Deborah Vitullo, Desiree Sanchez, Ginny Gomez, Jaime Molina, Deborah Helms.

Notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Agenda was reviewed.  Group already determined to make decisions using gradient consensus, so we will skip that item on the agenda.  Also moved "determining priority populations" item up on the agenda.
2. Introductions.
3. **Thoughts about last meeting?**  Like the idea of having strategies that cut across age groups (e.g. stressed families); this is a common theme among the PEI work groups. May be a smart way to go given limited resources.
4. **Stakeholders**.  Who is missing? La Manzana has a new director:  Celia Organista.
5. **Resource Material**.  DMH gave outlines of various programs.  Reaction/Comments? DMH is less rigid about their criteria about using best practice models, as long as we use logic model.  Programs need to be culturally competent.  We will need to evaluate the program(s).  Group noticed that there is very little in the DMH resources.  We will also look at other Counties and see what they are proposing.  Group mentioned parent training, and prenatal programs.  Triple P (Positive Parenting Program) was discussed briefly; there are some conversations in Santa Cruz about Triple P.
6. **Defining Priority Population**.  Discussed the 5 proposed priority populations, and after brief review/discussion narrowed the priority population for this group to "Children and Youth in Stressed Families", and secondarily to "Trauma Exposed Individuals".
7. **Stressed Families**.  Brain storm on what this looks like in the 0-5 age group:  poverty; substance abuse; child welfare (CPA has seen referrals for this age group go way up in last five year, mostly neglect, including substance abuse of parents); scarcity of resources (time, money, both parents working, one or two jobs); parents with mental illness causing stress on family (especially if they can't get services); immigration status; immigration experience and/or knowing someone that has been deported, especially in their own family; domestic violence (and not enough resources to address this issue); single parents; multi-generation gang involvement; large families (with few resources); homelessness; isolated families; families with special needs kids; divorcing families; families with parent(s) involved in criminal justice system; Latino families involved with CPS (who don't connect with resources, sometimes there is a waiting list for Spanish speaking services); people that speak a different dialect and have different cultural norms (such as marrying at a very young age) – they don't always enroll in school or seek "traditional" (main stream) services. Today we are just brainstorming; we'll narrow this down next time.
8. **Where do these families show up?**  Child welfare system (some served, some referred out); primary care physicians; head start and child care; substance abuse programs, and other families.  Dominican Hospital has a home health care program for babies born

there; Sutter and Watsonville hospitals do not have such a program. A lot of families with children ages 0-5 do not have a lot of "institutional" relationships, but we are aware of a lot of families already.

9. **Existing Programs.** Group discussed various resources, such as WIC; SPIN (Special Parents Information Network – CC Pineiro); Positive Discipline; Cara y Corazón and Papás (both are parent education programs, with the latter focusing on fathers). Cara y Corazón takes a holistic approach, and addresses not only children's behaviors, but also provides parents support, and looks at substance abuse issues; program is in the process of being evaluated (by CDC and SAMSA. Papás stresses working with fathers, but also looks at co-parenting issues; families commit for 18 months and the group looks at the individual skills of the parent, the parent-child relationship, the couple/parents roles and communication skills, the family of origin issues, and community supports/stressors. There have been 30 years of research for this program. There are other programs at the Walnut Avenue Women's Center, the Cradle Project, and Defensa. Discussed the importance of the engagement process for these and other programs. Some parents need more help engaging, and may need to be escorted to meetings at first. Transportation is also and issue.

10. **Build on existing resources?** Group talked about the idea of building on what exists, and not creating a new system. Also discussed having mobile services (that go where families are), and other natural settings (such as faith communities). Thought about the idea of "training the trainer" programs, that could include training consumers. Cara y Corazón already does this and Papás is interested in this, too.

11. **Decisions.** Interventions adopted should be multi-tiered going from universal approaches to selective interventions.

12. **Evaluation of Meeting.** What worked? What didn't? People liked the fact that Jerry checked the temperature of the group during the brainstorm, and the fact that this was a very collaborative, nice group building on each other's ideas. Liked the broad discussions, and some decisions being made.


**Next meeting**: Monday, August 4, 2008 from 9:30 to 11:30. 18 West Beach Street, Room 6, Watsonville, CA

<u>**Mental Health Services Act:  Prevention & Early Intervention**</u>
**Work Group: Ages 0-5**
**August 4, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Dane Cervine, Erika Hearon, Cathy Simmons, Shanna Clinton (for Ellen Timberlake), Susan True, Deborah Vitullo, Desiree Sanchez, Jaime Molina, Diane Oyler, Dorian Seamster, Laura Segura, and Shawn Henson.

1. Agenda was reviewed.
2. Introductions.
3. **Reviewed** the process so far, and gave information about the funding guidelines. (Between 840,000 to $1,050,000 for the 0 to 25 groups.)  Noticed that all the groups looked at trauma, onset and stressed families.  We are working on having 3 training events around these topics; these will be in the evenings.  Announced that we will have an evening presentation on August 25th by Gabriella Grant from On Track regarding trauma-informed services.  (**NOTE:**  this presentation has been rescheduled for Tuesday, August 19th from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz).
4. **Stressed Families**.  Recap of last meeting.
   a. **Indicators:**    (group added d – g)
      i. Child Welfare
      ii. Isolation
      iii. Divorce
      iv. Children acting out/in
      v. Domestic violence
      vi. Substance abuse
      vii. Appear in system with "specific problem"
   b. **Risk Factors:** (group added j-n)
      i. Poverty & homelessness [10]
      ii. Substance abuse [10]
      iii. Scarcity of resources (time & money) [2]
      iv. Parents with mental illness [10]
      v. Immigration issues [0]
      vi. Domestic violence [10]
      vii. Gang involvement (multigenerational) [6]
      viii. Criminal justice involvement [1]
      ix. Language issues [0]
      x. Lack of support system [6]
      xi. Chronic disease/disability [12]
      xii. Isolation  [2]
      xiii. Poor communication skills [2]
      xiv. "Kids having kids"  [0]
   c. **First Responders:**
      i. Child welfare system
      ii. Primary care providers
      iii. Head Start
      iv. Child care providers

        v. Substance abuse programs
      vi. Dominican hospital perinatal program
     vii. Family resource centers
   viii. Law enforcement
     ix. Shelters.

5. Group discussed the difference between indicators and risk factors and decided to list **measurable indicators:**
   a. Tox positive babies
   b. Child welfare (decrease in referrals, substantiated cases, 1st entry into foster care, recurrence, fewer out of home placements)
   c. Poverty measures
   d. Service wait lists (e.g., childcare, counseling)
   e. Pre-school expulsion
   f. Admission into substance abuse programs
   g. Witness to domestic violence
   h. Increased community involvement
   i. Improved communication skills
   j. Increased knowledge of child development
   k. Incarceration rates of parents
   l. System capacity
   m. Number of Spanish speaking mental health providers.
   n. Decrease in homeless youth
   o. Access to food bank.

6. **What about system changes?** Susan True said that First 5 did a "Service Integration Logic Model" that she will share with the group.

7. **Immigration issues:** noted that group realizes that issues may not be measured adequately.

8. **Risk Factors:** group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors. The risk factor that got the most dots was "chronic disease/disability" (12 dots), followed by "poverty & homelessness", "substance abuse", "parents with mental illness", and "domestic violence" (each with 10 dots). Group discussion of these results, including fact that even those that got no dots could still be of concern, and that families that have multiple risk factors really may need help (whether or not they were on this groups top list). We will look at other County plans to see if they have programs and/or outcomes that include these risk factors.

9. **Speakers:** Group discussion about who could possibly come to speak to this group about services for the zero to 5 populations. A long list was generated, and group acknowledged that we can't possibly invite them all and it may be problematic to invite some, but not others. Suggestion was made that everyone do a half page summary of programs that exist or are know about. Suggested speakers/topics were: Triple P; Papás; Cara y Corazón; Positive Discipline; Parent Education Collaborative; First 5; Beth Love of the Child Abuse Prevention Council; Public Heath nurses; Prenatal; SPIN; Voucher Project; Families Together; Nicole Young to provide overview of family support

10. **Resource Document:**  Draft of resource document was handed out.  This document is for mental health and substance abuse services in Santa Cruz County.  Suggestion was made that we add a column that includes the fee schedule and/or eligibility requirements.
11. **Next Steps:**  to review the resource document, look at existing programs (and do descriptions).
12. **Evaluation of Meeting:**  What worked?  What didn't?  Not much feedback today.  One person stated that he felt like this was a productive to talk about these issues; another said he liked the efforts to define terms we are using.

**Next meeting**:  Monday, August 18, 2008 from 9:30 to 11:30.  United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, CA

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 0-5**
**August 18, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Dane Cervine, Dani Beckerman, Deborah Helms, Deborah Vitullo, Desiree Sanchez, Diane Oyler, Ellen Timberlake, Erika Hearon, Linda Betts, Lindsay Steigner, Pam Bartholomew, and Susan True

1. Review of the agenda
   a. Evening presentations/meetings, dates and locations
   b. Review of top three priority populations (Trauma Exposed, Onset of Mental Illness, and Stressed Families)
2. Program speaker
   a. Susan True, Executive Director of "First 5," gave a brief overview of the history and goals of the programs.
   b. Workgroup would like to hear Jane Weed speak about the "Positive Discipline Curriculum," model (possibly for October meeting).
   c. Workgroup decided to forego future speakers due to time constraints.
3. Review of old business
   a. Identified three tiers (Universal, Selective, and Indicative) of services.
   b. Reviewed the workgroups priorities of "risk factors" for Trauma Exposed and Stressed Families populations.
   c. Reviewed who the Gatekeepers (first responders) are for children in stressed families
4. Outcomes
   a. Identified the outcomes of "Trauma Exposed," and "Youth and Children in Stressed Families," with regards to risk factors:
      i. Parents to have better understanding of child behavior development
      ii. Gatekeepers to be trained to detect early signs of mental illness in children
      iii. Access to early intervention (improves development)
      iv. Provide services once identified (easily accessible/culturally sensitive)
      v. To treat parents with mental illness (via rx, therapy groups)
      vi. Manage mental illness symptoms (life circumstances) to increase parenting effectiveness
      vii. To provide support for parents with mental illness (activity based)
      viii. To increase father involvement in families and in treatment
      ix. To educate parents effect upon a child's development
      x. Increase skills and support to deal with disease
      xi. Family: decrease in risk factors and increase in parenting effectiveness
   b. Workgroup needs to identify whether the outcomes are for the child, parent, or system.
   c. Ellen Timberlake asked, "Where are these goals showing up within the community?" (Offered to provide outcome info from HSD programs.) Would like to see a "cogent" system that would address universal education (via billboards, newspaper, public radio, word of mouth) that would incorporate a three-tiered system (universal, selective, indicative), with universal strategy and more treatment capacity.

5. Review of local resources
    a. Erika Hearon shared insights from the Family Resource Center (Live Oak)
        i. Services Family friendly, directed towards children
        ii. Because funding does not increase, collaborative methods work best.
        iii. Primary prevention strategy, "Positive Discipline Curriculum," meet with parent(s) and children, then just children. Widely embraced by community, accepted by families/cross cultures. Model is public domain and can easily be adaptive with minimal cost (Evidence-based practices more costly with regards to training and re-certifications.)
        iv. Implementation varies with site (Davenport versus Live Oak)
        v. Offer licensed counseling on a sliding scale, when identified, but finding this model less effective than peer counseling.
        vi. Resources (all) not there – "awareness" missing.
        vii. Surveys administered to parent at beginning and end of program
    b. MCR (?)
        i. Serves families in child welfare system (little services for children ages 0-3).
        ii. Pays for clinical supervisor and use interns to keep costs down (not enough (bilingual, bi-cultural) clinicians to provide assessment and services. No clinicians with training on evidenced-based practice.
        iii. Teachers trained in Positive Discipline Curriculum, used in school as classroom management tool.
6. The workgroup identified the need for additional data (suggestion to use ETR was offered).
    a. Susan True, Ellen Timberlake and Sherra Clinton to gather outcomes data from existing programs to help illustrate where our goals are showing up in the community.
7. Next steps for the workgroup are:
    a. Discuss "priority" outcomes (stay outcome focused)
    b. Come up with vision and outcomes statements
    c. Look at resource guide on evidenced based suggestions
    d. Discuss our group values on the community moving away from evidences based practices.
    e. What is our definition of strategy and outcomes

**Next workgroup meeting** will be 9/15/08 at United Way, and 9/29 at the Career Center in Watsonville (18 W. Beach St.)

**<u>Mental Health Services Act:  Prevention & Early Intervention</u>**
<span style="color:blue">**Work Group: Ages 0-5**</span>
**September 15, 2008 meeting notes**


Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, Cathy Simmons, Cecile Mills, Dane Cervine, Dani Beckerman, Deborah Vitullo, Deutron Kebebew, Dorian Seamster, Ellen Timberlake, Guy Grant, Jaime Molina, Laura Segura, Lindsay Steigner, Rocio Mendoza, Shawn Henson, Susan True, and Susanna Arevalo

1. Agenda Review
2. Introductions
3. Outcomes:
    a. All workgroups are nearing the end of their planning. 0-5 workgroup focusing on early development issues. 6-17 workgroups (6-12 & 13-17 workgroups combined) have the same population issues and are focusing on "Stressed Families," and "Trauma-Informed counseling Services for youth." 18-25 workgroup focusing on "Transition Age Youth." 26-59 Workgroup working on a "First Break" program. And the 60+ workgroup have worked on, "in-home services and other programs."
    b. If we identify a group in the plan, we must provide services for them. Must consider, "do we have providers for that group?"
    c. Outcomes must be measured with an evaluative component (wording will include strategy).
    d. Susan True offered the following sources for "screening," American Academy of Pediatrics (to catch issues early), "Ages & Stages Questionnaire," (screening tool using strength based method, no meds) and "California Institute for Mental Health."
4. Ellen Timberlake and Sherra Clinton from Human Services Dept prepared a draft Logic Model for this meeting, that "lists risk and protective factors already brainstormed by the 0-5 workgroup around stressed families and trauma exposed youth.  They took the list of strategies that have been either identified or discussed as examples.  The attempt is to put these strategies in universal, selective, and indicated categories.  This information and format will enable the workgroup to further discuss, prioritize, and adopt strategies.  Next we tried to differentiate between short, intermediate, and long term desired outcomes across the individual, family, and system level. All the outcomes listed reside in one or more of the following community plans:  the Child Welfare System Improvement Plan, Child Abuse Prevention Blueprint, and First 5.  Included is an attempt to demonstrate examples of evaluation measures. This logic model was adapted from the extensive work done by the Community Blueprint for Prevention."  Dane Cervine remarked that he was in favor of this logic model because of the MHSA language it incorporates and that outcomes seem cogent with specific strategies. The group proposed the following edits:
    a. Universal Strategies: 1<sup>st</sup> bullet, add "screening <u>all</u> for social…" 2<sup>nd</sup> bullet add "<u>to increase awareness and training</u>," add bullet #3, "Advocacy."
    b. Indicated Strategies: need to create one regarding the 0-3 age group, and the lack of actual treatment available.
    c. Short-Term & Intermediate Outcomes: reword the 2<sup>nd</sup> outcome to read, "Improved Child Bio, Psycho and Social Development

       d. System Factors, Universal Strategies: bullet #1, add "<u>physical</u>."
       e. System Factors, Selective Strategies: consider adding "gatekeepers."
       f. System Factors, Short & Long Term Outcomes: Reword to read, "To Improve New & Existing System Capacity and to Increase and Screen Collaboration."

5. Targeted gatekeepers (added parents and Community Based Organizations). Need appropriate educational needs for first 3 gatekeepers. The plan will need to show what each will be doing, their relationship to the community, and how they will continue communication with each other. The request for proposal should be crafted to encompass all gatekeepers that would force leveraging with community based organizations (targeting specific gatekeepers.
       a. Parents
       b. Primary Care Providers & Perinatal Program
       c. Family Resource Centers and Community Based Organizations
       d. Child Care and Headstart
       e. Child Welfare and Law Enforcement
6. Items that we need to try and come to some conclusions are:
       a. Pilot Program
       b. Assessment, Identification, and Treatment
       c. Program or proto type
       d. Program elements


**Next meeting** will be Monday, September 29, from 9:30-11:30, at Career Works on 18 W. Beach Street, Watsonville (room 2).

**Mental Health Services Act:  Prevention & Early Intervention**
**Work Group: Ages 0-5**
**September 29, 2008 meeting notes**

**Attendees:** Jerry Solomon (Facilitator), Linda Betts, Cathy Simmons, Dane Cervine, Dani Beckerman, Deborah Vitullo, Deutron Kebebew, Ellen Timberlake, Guy Grant, Jaime Molina, Laura Segura, Shawn Henson, and Sherra Clinton

1. Agenda Review
2. Introductions
3. Outcomes:
   a.  0-5 workgroup focusing on early development issues. All other workgroups have completed their recommendations; 6-17 workgroups (6-12 & 13-17 workgroups combined) have the same population issues and focused on "Stressed Families," and "Trauma-Informed counseling Services" for youth. The 18-25 workgroup recommended "Transition Age Youth" counseling/case mgmt for youth with a focus on those aging out of the system. The 26-59 workgroup have recommended a "First Break" program. And the 60+ workgroup have recommended "in-home services and other programs."
   b. The workgroups focus is Stressed Families exposed to trauma
   c. Emphasis on 0-3
   d. Strategies: Screening, parent education, and services
   e. Include the following language, "father, gender, and family composition friendly."
4. After a review of the revised Logic Model (previously prepared by Ellen Timberlake and Sherra Clinton from Human Services Dept.), this workgroup recommended the following changes:
   a. Under "Factors that may increase risk of serious mental health issues in children," add another bullet, "Trauma."
   b. Under "Universal Strategies," add "and others" to "Screening by Pediatricians."
   c. Under "System factors that may increase risk for serious mental health issues in children," add another bullet, "Lack of collective knowledge and system awareness."
   d. Under "system factors that may increase protection against serious mental health issues in children," add two additional bullets, "Trauma-Informed Services," and, "Preventive Services."
   e. Under, "Indicated Strategies," add, "(with emphasis on children 0-3)."
5. **Next steps:** Focus groups and Key informant interviews during the month of October, with people who have not been able to attend the workgroup meetings. They will review recommendations (specific to the focus group) and respond back based on their personal experience. This information and the workgroups final recommendations will be submitted to county staff to prepare a "draft" plan for the MHSA Steering Committee to review. November we will reconvene with all workgroups to review the draft and submit additional changes/recommendations as needed. County staff will revise the draft and submit for a 30-day public review and set a time for public comment (to be held during a Mental Health Board meeting).

6. This group has finished their recommendations. **Thank you!**

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Workgroup: Ages 6-12**
**June 30, 2008 Meeting Notes**

1. Introductions
   a. Jerry Solomon – Contracted through the County as facilitator for the PEI planning process
   b. Charise Olson (representing COE, JoAnn Allen/oversees student support services)
   c. Rita Flores – Asst. Dir. for Family Services
   d. Cecile Mills – Educator/worked with students (6-12 yr olds) since 1971 (goal: what is working and not working)
   e. Lisa Russell – Sr. Research Scientist with ETR Assoc./Background in Mental Health research
   f. Leticia Gómez – Mgr of PVPSA (Pajaro Valley Prevention & Student Assistance)
   g. Rosio Rodriguez – representing Latino community
   h. Mariana España – Women's Crisis Support, manage children/youth program
   i. Stan Einhorn – Program Mgr with Children's Mental Health services/oversee contracts for providers in the community
   j. Eileen Brown – Director of Student Services for Santa Cruz City Schools
   k. Tove Beatty – Executive Director of Mountain Resources serving the San Lorenzo Valley
   l. Kate Venturini – Mother of consumer/child
2. Review of workgroup ground rules and the state Department of Mental Health (DMH) guidelines for Prevention & Early Intervention
   a. No hidden agenda's
   b. This process will be transparent
   c. We should be proposing programs that "leverage" funds (i.e. give office space for a program, provide admin support, or take on an intern and do supervision)
3. Agenda's brought to this process
   a. Jerry – known throughout community and will add integrity to this process; Outcomes would like to see youth and senior's identified early and their needs addressed sooner, and services in non-traditional settings
   b. Rita Flores – Family Services is a contractor with the county Mental Health department (gatekeeper for kids 0-21), because agency is a non-profit, concerned about loosing funding
   c. Charise Olson – County office of Education, represent youth/ear and voice for education on early signs of mental illness (student support services to assist youth outside of the school). No dollar agenda
   d. Eileen Brown – not here for dollars, envision a coordinated plan involving all agencies, education & training for counselors/teachers on noting signs of early mental illness to prevent school failure
   e. Kate Venturini – system does not work well for people trying to find service, need a better system to find all available services, clearer pathways for consumers coming into the system.
   f. Tove Beatty – Mountain Resources community is integrated with the San Lorenzo Valley School District, providing 30 hours a week of free counseling for 1.5 years. Would like to see services locally accessible to families. Interested in

community-based organizations. Not interested in funding but is concerned about "matching funds" transparency. Envision consolidating all resources.

g. Stan Einhorn – from the county perspective; implementation of best practices of how to get services to kids with drug & alcohol problem, and juvenile justice problems that work. We need a better means of getting mental health and resource information out to the public (i.e., media, websites).

h. Leticia Gómez – share what we know through the community, what's worked and what hasn't. Cultural Competency is needed to improve existing programs; take a holistic approach to families, following them thru the services they use.

i. Lisa Russell – As a researcher, hoping to understand community needs and preferences and see what sort of grant writing I could do to try and bring in more money to this community to see that those things that are at risk of falling out of the fundable list don't.

j. Cecile Mills – Want to see evaluations on what we are working on, how effective has it been, are we going to do it again, whom do we go to get questions answered adequately, need a good reference library. Utilize the web to have a site that is a resource, a single portal, for people to use as a one-stop shop, including a feedback option. Utilize existing programs in community to do their own surveys and share this information with each other.

k. Mariana España – Improve the crisis line (currently, volunteers go through 60+ hours of training, but are unable to counsel), used as a gateway for referrals. Concerned about the children that currently are not using services but do need support.

4. Priority populations, per the DMH, to focus on in this workgroup
   a. Trauma exposed
   b. Individuals experiencing the onset of a serious mental illness
   c. Children/Youth in stressed families
   d. Children/Youth at risk for school failure
   e. Children/Youth at risk of experiencing criminal juvenile justice involvement
   f. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.

5. Workgroup decisions to make
   a. Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
   b. Making sure we have the appropriate stakeholders involved with this process. Who is not here (Per the state DMH guidelines, we must be sure we have representation from all groups.)? Must be mindful of these groups and make an effort to get information from them so that it is fed into our process. (Current stakeholders may represent more than one group.)
      i. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
      ii. Education
      iii. Consumers and/or their families

        iv.  Providers

        v.  Health organizations

        vi.  Social Services

        vii.  Law Enforcement (due to understaffing and having this group participate in meetings, we will do a focus group or invite one/two officers to sit in one meeting and concentrate questions to them)

        viii.  Recommended (having value) but not required would be, Community Family Resource Centers, Employment, and Media

6. Ideas and thoughts
   a. Can see this age group benefiting a lot, which would accomplish the purposes of this money in terms on long-term impact.
   b. Would like to see some way of tapping into 6-12 years olds, those involved who are successful, and those who are struggling.
   c. Educate law enforcement, emergency room staff, and 911 operators on how to deal with children having an episode.
   d. The county could put something similar to a virtual space on line for kids to access and use to share stories with anonymity.
   e. Have a mental health court to deal with only those identified with a mental illness, and train court personnel on mental health illness. Some reactions to this are that people with mental illness do not trust these courts because they are based on fear (Marin County model).
   f. Hook up volunteers or mental health providers with law enforcement and ride with them for purposes of identifying when someone may be having a mental break or physical problem.
   g. Update the county data base for resources

7. State values and guiding principles and the expectation that we are aligned with these values;
   a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
      i.  Leveraging resources
      ii.  Stigma and discrimination reduction
      iii.  Recognition of early signs
      iv.  Integrated and coordinated systems
      v.  Outcomes and effectiveness
      vi.  Optimal point of investment (biggest bang for the buck)
      vii.  User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

**Next workgroup meetings:**
7/14/08, County Office of Education, 10-12
7/28/08, Watsonville Towers (confirmation pending)

**Mental Health Services Act:  Prevention & Early Intervention**
**Work Group: Ages 6 to 12**
**July 14, 2008 meeting notes**


Attendees: Jerry Solomon (Facilitator), Stan Einhorn, Cecile Mills, Leticia Gómez, Rocio Rodríguez, Tove Beatty, Mariana España, Eileen Brown, JoAnn Allen, Rita Flores, Lisa Russell, Kate Venturini, and Alicia Nájera.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1.  Agenda was reviewed.  No changes were made.
2.  Introductions.
3.  Old Business:
4.  **Decision Making**:  Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote.  Solution?
5.  Cecile presented a letter to Jerry and read it to the group expressing her concerns about the PEI planning, including her belief that the planning is not inclusive, there are insufficient numbers of family members and consumers, the meeting times are inconvenient, most people get paid to be at meetings (but not consumers or family members), meeting times are not posted and meetings are in "lecture mode".
6.  Tove pointed out that identifying as a consumer is confidential, and that it is presumptuous to think that everyone at the meeting "is on the clock".
7.  JoAnn, Stan and Eileen all presented ideas about representing and/or including input from 6 to 12 year olds and/or their families.
8.  Jerry told group about meetings he and Alicia had with MHCAN (Mental Health Client Action Network) and Mariposa.  Both agencies said that the best way to get consumer involvement is to have focus groups (which can be held at their sites).  DMH also encourages alternate approaches to gaining input from stakeholders including surveys, key informant interviews, and focus groups.
9.  Cecile mentioned that the meetings were not posted at MHCAN or Mariposa, and said that the County Website says the "survey is closed".  Alicia was not sure what this was about.  Jerry said he would appreciate hearing concerns ahead of time so that these concerns can be addressed rather than waiting until the meeting and focusing upon complaints rather than the task in front of the group.  Jerry will follow up with Mariposa and MHCAN about posting the meeting times for the PEI workgroups.
10. Returned to question of decision making… Various persons chimed in about consulting with 6 to 12 year olds/families/representatives about our process, doing web surveys to get input, or accessing families to get input.  It was suggested that meetings be videotaped.  Jerry noted that how we get input is driven by what this group decides.
11. **Obtaining Stakeholder input**.  Should we narrow down the focus, and then get input?  Some people will not get addressed due to limited funds.
12. Discussed doing a resource map, then we will know where the gaps are.

13. How do people get into the system? Where do they go for services? Cecile said we might have some success with 6 to12 year olds; can do a questionnaire with teachers. Can meet with family members (not necessarily do a survey).
14. JoAnn mentioned that she has some resources (tied to a grant) that group may use that will also fulfill her requirements.
15. Group discussed how to narrow this down… Stan pointed out that PEI will not fund services that already exist, plus programs need to be evidence-based, and preventative (we want to keep kids from getting into the system).
16. Discussed education as part of intervention. Teachers, parents, primary care physicians all need better education about early intervention and referrals for serious mental illness seen in children. Teachers get some education, but also feel a lot of pressure. If child doesn't qualify for special education programs there are often no other places to refer within the school system.
17. Program ideas: promote mental health and well being (for teachers and students), family support (e.g., list of what to do, not every child needs a psychiatrist). Also talked about natural access points (e.g. clergy), and how to get information out about programs that do exist.
18. Group focus narrowed down to Trauma, Onset of Mental Illness, and Stressed Families. (Can address School Failure and Juvenile Justice Involvement via these others.)
19. Next Steps: Look at resources compiled by DMH and explore models. Which has the most component that we need? Look at these (and possibly other models). Also need to review ASR data. Do we need additional data?

**Next meeting**: Monday, July 28, 2008 from 10 to 12 in Watsonville (294 Green Valley Road, 3rd Floor, room 320).

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group:  Ages 6 to 12**
**July 28, 2008 meeting notes**

Attendees: Ginny Gómez, Leticia Gómez, Eileen Brown, Linda Pérez, Mariana España, Kathleen Kilpatrick, Lisa Russell, Rocio Mendoza, Alicia Nájera, Jerry Solomon.

1. Agenda Review.  Will move up reviewing local resources on the agenda.
2. Introductions.
3. **Review Local Resources**: Presentation of the Pajaro Valley Unified School District Integrated Mental Health Services by Linda Perez, of Pajaro Valley Prevention & Student Assistance (PVPSA).  PVPSA provides services to the Pajaro Valley Unified School District.  Pyramid of services includes:
    a. <u>Mental Health Foundation and Maintenance</u>: School Resources and Supports for Healthy Development (such as classroom teachers, guidance counselors and academic support programs, parent involvement, school safety personnel, after school programs, sports, arts, and extra curricular activities).
    b. <u>Universal Prevention</u>: Education, skill building, and wellness programs (such as youth development, school health curriculum, bullying and other prevention programs, parent education and involvement programs, school nurses.
    c. <u>Selective Prevention</u>: Screening, monitoring, and brief intervention (such as Seven Challenges insight/prevention groups, Primary Intervention Program (EMHI), Families and Schools Together (FAST), Primary Care Provider referrals, conflict resolution teams).
    d. <u>Indicated Prevention</u>: Early Intervention and treatment (such as, secondary student assistance program, seven challenges insight/prevention groups, drug medi-cal minor consent services, Kida Korner elementary student assistance program, student study teams, school psychologist).
    e. <u>Mental Health Treatment</u>: individual and family counseling (such as Safe Schools/Health Students dedicated County clinician, probation team and Wrap-around services, AB3632 SDC-ED Mental Health services, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Supportive Intervention Services (SIS), Supportive Adolescent Services (SAS), and Safe Schools/Healthy Students Counseling).
    f. <u>Crisis care</u>: Mental Healthy Emergency Response Team, Suicide Hotline, Criminal Justice Interventions.
4. Despite all these services what **challenges** still exist?  Teachers feel pressure from "no child left behind"; still need to demonstrate how programs support academic success; confidentially/privacy issues and information sharing; lack of common language between mental health and education providers; turf issues (need integrated approach and maximize resources); fragmented funding stream (need consistent funding); staff changes/turnover.
5. **What is working?**  Do have resources, do social marketing, using evidence-based models.  Children that get services through Kids Korner seem to feel comfortable with counseling (a way of addressing issue of stigma and discrimination).  Issue of how expensive evidence based models was discussed.  For example, one program required they purchase the training (about $7,000 per person), pay for the trainer to observe the

staff, pay for the evaluation, lots of administrative time, and staff only get certified for 2 to 3 years (then need to be re-certified). If there is staff turnover then need to get new staff trained).

6. **Decision Making:** The ideal is to reach a consensus, but should we need to vote on an item who would be allowed to vote? Group discussed various options and decided that persons that have attended at least 50% of the meetings, and 3 of the last 5 meetings can vote. Also, the group agreed that a person could send a proxy for their vote, and only one vote per agency. (Note: Leticia Gomez and Linda Perez, both of PVSA, will alternate attendance of this meeting.)

7. **Priority Populations:** Last time group narrowed it down to <u>children and youth in stressed families</u>, <u>trauma exposed individuals</u>, and <u>onset of serious mental illness</u>.

8. **What does Onset of Serious Mental Illness look like** for this age group? Behavior (either acting out or very withdrawn), school avoidance, pattern of missing school, somatic symptoms, parents in distress about their child, hyperactivity/attention issues, violence, bullying (both the victim and the perpetrator), Primary Care Provider or emergency services, day care centers, home schooled children, kids that show up at domestic violence shelters, anxiety (fears, phobias), depression, compulsive behaviors.

9. **Next Time:** think about what <u>children and youth in stressed families</u>, and <u>trauma exposed individuals</u> look like.

10. **Feedback** about meeting: Liked the informational presentation; perhaps we could do another presentation on trauma exposed (Mariana can talk to Gabriella Grant about this, and see if she could do this on August 25th, perhaps in the evening); liked the discussion, and narrowing down. **Note:** there was a discussion about the possibility of having an evening meeting.

**Next Meeting**: Friday, August 11, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group:  Ages 6 to 12**
**August 11, 2008 meeting notes**

Attendees: Mariana España (Defensa de Mujeres/Women's Crisis, in charge of children/youth programs), Pam Barthalomew (Peer to Peer for Nami, family member and consumer), Tove Beatty (Executive Director of Mountain Community Resource Center, family member), Cecile Mills (Teacher, consumer), Stan Einhhorn (Program Manager at Children's Mental Health, family member), Lisa Russell (ETR, researcher, family member), Alicia Nájera (MHSA coordinator), Jerry Solomon (facilitator, family member).

*Note:  There was a mix up on the agenda as to the location and start time of the meeting, so the group had a slight delay.  (The location was incorrectly listed as the United Way, instead of the Mountain Community Resource Center, and the time was listed as starting at 9:30, instead of 10.)

1.  Introductions.
2.  **Funding Guidelines:**  The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000.  These amounts are guidelines only and not set in stone.
3.  **Priority Populations for all groups** have been identified, as follows:
    a.  0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b.  6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c.  13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d.  18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    e.  26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    f.  60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
4.  Evening **presentations/meetings** announced.
    a.  **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b.  **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz.  We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes.  Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c.  **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.   **NOTE:**  Alicia shared that there has

been some difficulty in lining up a presenter; one resource stated that the Governor has told them not to work (due to budget). Tove mentioned that ASR may be able to do presentation; she saw them do one a couple of weeks ago on family profiles.

5. **Data:** Cecile presented a letter with a request that we start gathering data about the services in Santa Cruz County (including number of people served, number of people eligible for services, types of treatments, etc). Stan mentioned that there is a 17 year report that is available at the County website that gives this time of information for this age group. With PEI we will be able to set up our system ahead of time to gather the data we want to collect. Discussion focused on what are we doing, is it working, and what do we need to do to make them better (instead of "re-inventing the wheel").

6. What are the **risk factors** for children and youth in stressed families? Group brain stormed the following: domestic violence; exposure to violence, including emotional/physical/sexual abuse; parental involvement with the criminal justice system; parent with a mental illness; lack of access to basic needs (food, clothing, shelter); socially marginalized (not engaged with parents, extra curricular activities, fun); not having adequate adult supervision; latch key children; lack of transportation; residential and/or school instability; foster/kinship care; parental literacy; poor parenting skills; reactive (not proactive) in seeking services; poor self care (including nutrition).

7. What are **indicators** for children and youth in stressed families? (Indicators differ from risk factors in that they are measurable.) Group came up with the following: school attendance; school failure; school expulsion; prodromol (behavioral acting out/in); lack of social; substance abuse (huffing, smoking, etc); "virtual" lives; anti-social behavior; cruelty; late developmental milestones; body weight; increased risk taking.

8. Who are the **gate keepers** for children/youth in stressed families: parents; family members; primary care providers; emergency services; day care centers; home school providers; teachers and other school personnel; coaches; social services (family resource centers, ymca, etc); faith-based communities.

9. **Speakers?** Group talked about having speakers come to this meeting for the purpose of who is doing the work for this age group already, and what are the needs? Ideas for speakers includes: Cecile Mills (what is not available); family resource centers panel (to include family advocates, and discuss what services are being provided and what are the needs); Nicole Young; Jaime Molina (Cara y Corazón); Defensa (domestic violence and sexual assault response); Family Services; Families Together; Parents Center; juvenile justice. Tove Beatty agreed to pull together a panel of the family resource providers, as well as contact the juvenile justice contact she has.

10. **Resource Document:** Handed out the draft resource manual and asked people to look it over and inform us about any corrections/changes.

11. **Next Time:** think about what trauma exposed individuals look like.

12. **Feedback** about meeting: Pam said she would like to do more outreach to families. Jerry reminded group that we will do focus groups to get additional feedback.

**Next Meeting**: Friday, August 25, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group:  Ages 6 to 12**
**August 25, 2008 meeting notes**

Attendees: Tove Beatty, Stan Einhhorn, Cecile Mills, Brandy Shaw, Leticia Gomez, Charise Olsen (for Joanne Allen), Guy Grant, Rocio Mendoza, David Bianci (for Rita Flores), Ginny Gomez, Laura Segura, Alicia Nájera, and Jerry Solomon.

1.  Agenda Review.
2.  Introductions.
3.  **Speakers:  Tove Beatty and Brandy Shaw**.  Spoke about the Family Resource Centers in Santa Cruz County:  La Manzana, Mountain Community Resource Center, Live Oak, Familia Center, and the Davenport Resource Center.  Resource centers often try to be a one-stop shopping center for resources for families; services have diminished over time due to cut backs in funding.  Some do offer limited case management; Mountain Community resource center offers free mental health counseling.  Resource centers do not have the resources to deal with long-term issues of drugs, poverty and housing.  The resource centers in our county do collaborate (such as the Parent Education Collaborate that offers parenting education using "Positive Discipline"), but it is a challenge because the needs of each community are unique. Mountain Community and Davenport offer disaster response.  Brandy Shaw spoke about "Families Together" which works with families referred by children's protective services.  It was noted that there are hardly any resources for children ages 6 to 12.
4.  **Evening presentations/meetings** announced.
    a.  **Tuesday, August 19th** we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b.  **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz.  We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes.  Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c.  **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is Dr. Rivtka Greenberg.
5.  **Stressed Families Risk factors**. Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, but had to put the rest on other factors.
    a.  Violence/abuse/neglect [12]
    b.  Substance use/abuse [14]
    c.  Parental mental illness/incarceration [0]

      d. Economics [8]
      e. Foster care [0]
      f. Latch key kids [0]
      g. Nutrition [8]
      h. Socially marginalized [7]
      i. Parental skills/supervision [14]

6. **Onset of Mental Illness Risk Factors**: Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
   a. Change of behavior [6]
   b. School attendance [7]
   c. Somatic symptoms [11]
   d. Parents expressing concern [6]
   e. Victims of violence [2]
   f. Bullying [8]
   g. Prodromol emotional/behavioral symptoms [10]
   h. Children of parents receiving support/intervention [1]
   i. Trauma [11]
   j. Nutrition [4]

7. What are the **risk factors** for trauma exposed youth?  Group brain stormed the following: poor parenting skills, economics, drugs/alcohol, attention issues, ptsd, lack of support for child, continued exposure to trauma, targeted at school, medication effects (leading to increased suicidality), normalization/desensitization to violence, decreased ability to assess trauma (providers/teachers), increase support for training "incentives", decreased understanding of mental illness issues, "vocabulary" of trauma.

8. **Outcomes:** Brainstorm about possible outcomes (system wide, by program or by consumer):
   a. To improve parent-child relationships
   b. To increase school success to targeted students
   c. To train gate keepers in early detection and appropriate intervention
   d. To decrease bullying of targeted students
   e. Children to have a satisfactory experience with gate keepers
   f. To promote kids abilities and increase their access to strategies for emotional/physical support
   g. To reduce exposure to trauma
   h. Increase access to mental health services to consumers
   i. To offer mental health advocates at each school

9. **Next Steps:** Review Department of Mental Health Resource manual to stimulate thinking; think about what programs we are interested in.

**Next Meeting**:  Friday, September 8, 2008.  From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 6 to 12**
**September 8, 2008 meeting notes**

Attendees: Stan Einhhorn, Cecile Mills, Leticia Gomez, Joanne Allen, Guy Grant, Rocio Mendoza, Rita Flores, Ginny Gomez, Mariana España, Lisa Russell, Alicia Nájera, and Jerry Solomon.

1. Introductions.
2. Recap of previous meetings.
3. **Trauma Exposed Individuals Risk Factors**: Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
   a. Continued exposure to trauma (8)
   b. Normalized/de-sensitized to violence (8)
   c. Inadequate parenting skills (11)
   d. Drug/alcohol exposed (7)
   e. PTSD (10)
   f. Targeted at school (7)
   g. Effects of RX (9)
4. **Speakers:** Joanne Allen and Leticia Gómez on "bullying". Joanne works for the County Office of Education and Leticia works at Pajaro Valley Prevention & Student Assistance Program. Joanne trains schools about what bullying looks like, how to assess it, and what to do about it. She states that it is necessary to have schools create a culture and climate where bullying behavior is not tolerated. Three things that can be done: identify areas (where it is happening); provide support for the "target" (skills development and counseling); and separation from the bully (awareness, support, counseling). The big think is for schools to recognize the problem. Leticia talked about the model program that PVPSA is using for PVUSD. It is a very costly (evidence-based) model that they got funding for (but only for 8 more months). After schools get trained the number of reports goes up.
5. **Outcomes Ages 6-12 (also shared the outcomes for workgroup 13-17).** Both work groups address stressed families and traumatized youth. Discussed the ideas this group has come up with and added/edited them:
   a. Targeted at-risk youth will be offered trauma-informed services.
      i. <u>Strategy: Identify and provide rapid access to school-based counseling and support services for those being bullied and bullying.</u>
         <u>Evaluation:</u>
         Utilization data
         Consumer goal achievement measures
         Consumer satisfaction measures
      ii. <u>Strategy: Create and support a mental health advocate program within each school to assist in early detection and prevention of serious mental illness by offering emotional/physical support to targeted youth.</u>
         <u>Evaluation:</u>
         Rates of suspension/expulsion

Attendance data
Reduced exposure to trauma
Utilization data
Consumer goal achievement measures
Consumer satisfaction measures

   iii. Strategy: To provide on site advocacy (in a designated space) at all schools
   iv. Strategy: To provide positive role models/mentors

 b. To improve the quality of life for targeted stressed families in order to decrease the risk of violence, suicide, and other family traumas youth might be exposed to.

   i. Strategy: Offer professional/peer-to-peer mental health individual and/or group services on-site at all FRCs.
    Evaluation:
    Utilization data
    Consumer goal achievement measures
    Consumer satisfaction measures

   ii. Strategy: Improve the parenting skills of both mothers and fathers.
    Evaluation: Standardized pre- and post- measures regarding knowledge of parenting strategies and non-violent communication patterns.

   iii. Strategy: To offer outreach services to families who are hard-to-reach/resistant to services. (Discussed possibility of offering services at different venues, such as probation, ATO, organized sports, faith organizations, parenting groups at schools, and in the home.)

 c. To educate/train targeted gatekeepers to identify youth exposed to trauma and/or at risk of a serious mental illness and how to effectively assist them.

   i. Strategy: Train all medical settings serving targeted groups to identify early signs and symptoms of mental illness and/or trauma exposure. Offer service providers helpful ways to respond to youth/families.
    Evaluation: Referral data from service agencies.

6. **Next Steps:** Need to finalize our list of proposed programs.


**Next Meeting**: Friday, September 22, 2008. From 10 to 12 at United Way (in the Begonia Shopping Center), 1220-C 41st Avenue, Capitola, Ca.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group:  Ages 6 to 12**
**September 22, 2008 meeting notes**

**Attendees:** Alicia Nájera, Cecile Mills, Ginny Gomez, Guy Grant, Linda Betts, Linda Perez, Lisa Russell, Mariana España, Rita Flores, Stan Einhorn, and Tove Beatty.

1. Introductions.
2. Recap of previous meetings.
3. Priorities:
   a. Youth in Stressed Families
      i. Inadequate Parental Skills/Supervision
      ii. Substance Use/Abuse
      iii. Exposure to violence/abuse/neglect
   b. Trauma-Informed
      i. Inadequate Parental Skills/Supervision
      ii. PTSD
      iii. Effects of medication on youth
4. Gatekeepers:
   a. Parents/Family
   b. Peers/Youth
   c. PCP's (primary care physicians)
   d. Teachers/School personnel
   e. Activities – i.e. Coaches, Boys/Girls Club, Little League
5. **Outcomes Ages 6-12** (because many of the recommendations mirrored the 13-17 workgroup, collapsed both into one document).  Reiterated that this group determined that their target population is LGBT and Latino youth. Discussed the outcomes draft and came up with the following changes:
   a. When noting "LGBT and Latino youth" in parentheses, use i.e. at the beginning and eliminate etc. at the end.
   b. Change "non-traditional settings," to "non-clinical" or "non-clinical based" settings.
   c. Include "school based services" in non-clinical settings.
   d. Outcome 1, strategy 1, and bullet 2: Delete "classes," and insert, "training for parents." Insert, "i.e. in the parenthesis and add, "effects of medication on children. Move, "FRC's," to end of sentence with parentheses around it and use "i.e." Add another bullet for "support/resource access."
   e. Outcome 2, delete "LGBT and Latino." Delete, "and," after peer and add / before, "professional." Delete "targeted," and add, "LGBT, Latino and other marginalized." Strategy 2, add, "and other," after, "school-based." Delete the last sentence. Add, "Strategy 4 – PCP's must be educated on trauma-informed services."
   f. Outcome 3, add, "resources," after mental health services. Add, "Evaluation – tract usage, utilization, and consumer satisfaction."

g. Outcome 4, Strategy 1, delete, "the Training Academy," and add back in after, "venues," within parentheses and i.e. before it. Add, "Strategy 3 – Maximize leveraging with state funds." Add, "Evaluation – Standards for assessing media."

h. Outcome 5, Strategy 2, delete, "through the," and add, "at venues (i.e. Training Academy)." Strategy 3, add, "at risk of suicide," after, "symptoms of mental illness." Delete, "helpful."

6. **Next Steps:** Focus Groups in October. County Staff will prepare a draft based on the recommendations from all workgroups and focus groups and make cost estimates. November we will hold two "all workgroup" meetings to review and make changes as needed. Recommend workgroup members attend the Public Review of the plan at the Mental Health Board meeting when notified.

This workgroup has completed their recommendations.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Workgroup: Ages 13 - 17**
**July 2, 2008 Meeting Notes**

1. Introductions
2. Review of workgroup guidelines and rules
   a. We are to create and foster an integrated system
   b. The state has mandated that we use the Logic Model (will need to document that we are doing this and the State will evaluate us).
   c. Values and Guiding Principles
      i. Transformational programs and actions
      ii. Leveraging resources
      iii. Stigma and discrimination
      iv. Recognition of early signs
      v. Integrated and coordinated systems
      vi. Outcomes and effectiveness
      vii. Optimal point of investment
      viii. User friendly plans
      ix. Non-traditional settings.
   d. The group will need to review its decision making model; we will try for consensus, and if unable to reach consensus use a majority vote to decide our recommendation. The group needs to decide who can vote on the final decisions made before that time arises.
3. Workgroup member's & agendas
   a. Jerry Solomon, Facilitator, Psychologist & MFT
   b. Benita Mugnani (Ex. Dir. Survivor Healing Center) is the voice for those who experienced child sexual abuse. Her agency would like to apply for funding.
   c. Rita Martinico (Director of Youth Programs at Walnut Avenue Resource Center) She is attending these workgroup meetings to be educated about the process, learn about other services in the community (working with youth 11-17) and have a voice at the table. They are considering applying for funding
   d. Allen Harrison (Youth Leadership Coordinator for Family). Here to learn about this process, wants to make sure the voice of the youth are heard and make changes in the services they receive.
   e. Michael Paynter (Coordinator at the County Office of Education) wants to be sure the best methods for offering services will get applied to this age group.
   f. Carly Galarneau (Suicide Prevention Service) here to be a part of the process and learn about other organizations, form partnerships with other organizations and interested in funding if opportunity presents itself.
   g. Jesus Ramirez (Coordinator and Youth Radio Producer for Radio Bilingue) here to be part of process and interested in funding.
   h. Holly Heath (Mental Health Client Supervisor at Children's Mental Health) here to support the creation of more services for her clients.
   i. Jenny Sarmiento (Chief Ex. Officer of Pajaro Valley Prevention Student Assistance) providing services to children who live in the Santa Cruz, Watsonville, and north Monterey area. Wants to be part of the process and to explore the possibilities of applying for funds. Wants to make sure we maximize

these resources. As part of a cooperative effort between Healthy Starts, school districts, psychologists and other mental health workers in Watsonville, they are looking at gaps in services for uninsured children. She hopes that through these funding sources we can provide services to children so they can avoid the more costly decision to seek services in emergency rooms.

j. Bill Manov (Chief of Alcohol and Drug Services for the County of Santa Cruz), there are commonalties of risk and protective factors that predict mental health problems and alcohol and drug abuse. His agency has developed a lot of community partnerships and prevention strategies with research to back them up. A lot of local infrastructure already exists to provide prevention services and hopes we "do not reinvent the wheel." He is interested in dual diagnosis issues that will capitalize on this infrastructure and wants to explore how we can do this together with PEI. Not necessarily interested in funds for his program, but is interested in strengthening the youth development structure, our contract agencies and community partners.

k. Jorge Savala (Leader for COPA) COPA was recently formed when 24 different churches, congregations, schools, and nonprofits in Santa Cruz and Monterey County met to develop plans for affordable housing, health care and community safety. He is here to focus upon community safety and to develop additional after school and recreational programs for the youth to keep them out of the justice system (and I hope to stop gangs).

l. Ron Indra (High School Teacher in Social Studies) receives a small grant from the Community Foundation of Santa Cruz to construct an assessment tool for school districts and schools to use to determine safety issues for GLBTQ.

m. Janet Seminerio (Women's Crisis Support) They have intervention programs for domestic violence and sexual assault and have been offering established models of prevention services for 10 years. We are interested ink exploring the creation of a program that addressing all areas of family violence. Our experience could contribute to the whole idea. We have programs in place that could be appropriate to be expanded or adapted to address that need, and would like funding for that.

n. Martine Watkins, representing JoAnn Allen (County Office of Education). Just received a grant to consolidate agencies to have a better collaborative work relationship with each other. Want to know how we can fit into the group and figure out where we can assist and help.

o. Shane Hill (Clinical Psychologist, specializing in Transgendered People) here as a voice for the Transgendered community. He currently offers trainings at Scotts Valley Elementary School on Trans youth and Children's Mental Health. He hopes to have these trainings offered at all the schools resulting increased cultural competency when working with transgender children.

p. Bill McCabe (Asst. Dir. of Youth Services) interested in the process, not necessarily in funding. Have many programs for youth and LGBT youth.

4. Planning Process
   a. Next step, pick a priority population from:
      i. Children/Youth in stressed families
      ii. Children/Youth at risk of school failure
      iii. Children/Youth at risk of juvenile justice involvement

        iv.  Trauma exposed

        v.  Experience onset of serious mental illness

  b.  State will do own initiative on Suicide Prevention and Stigma reduction of the mentally ill.

  c.  Steering Committee will set funding percentage

  d.  Program/s must be evidenced based with an evaluation component built in

  e.  Need representation from stakeholders, as identified by the State

  f.  Identify missing stakeholders

        i.  Need Latino outreach

        ii.  African-American community outreach

5. Priority populations, per the DMH, to focus on in this workgroup

  a.  Trauma exposed

  b.  Individuals experiencing the onset of a serious mental illness

  b.  Children/Youth in stressed families

  c.  Children/Youth at risk for school failure

  d.  Children/Youth at risk of experiencing criminal juvenile justice involvement

  e.  Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.

6. Workgroup decisions to be made:

  a.  Narrow down priority population recognizing all have needs. After we've determined which populations we are focusing upon we can collect data that we need to start making recommendations about programs for prevention and early intervention in those areas.

  b.  Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.

        i.  Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.

        ii.  Education

        iii.  Consumers and/or their families

        iv.  Providers

        v.  Health organizations

        vi.  Social Services

        vii.  Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).

        viii.  Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media

7. Review of MHSA PEI values and guiding principles. All in attendance stated that they were aligned with these values and principles.

      a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
  i. Leveraging resources
  ii. Stigma and discrimination reduction
  iii. Recognition of early signs
  iv. Integrated and coordinated systems
  v. Outcomes and effectiveness
  vi. Optimal point of investment
  vii. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

**Next meeting**: Wednesday, July 16, 2008 from 9:30 to 11:30. County Office of Education, 809 Bay Avenue, Capitola

**Work Group: Ages 13 - 17**
**July 16, 2008 meeting notes**


Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Jenny Sarmiento, Holly Heath, Bill McCabe, Nora Rhaimian, Martine Watkins, Alexis May (for Carly Galagneau), Emily Marsh, Mary Cross, Denise Gannon, Ginny Gómez, Jesús Ramírez, Janet Seminerio, David True, Jaime Molina, and Yolanda Pérez-Logan.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1.  Agenda was reviewed.  No changes were made.
2.  Introductions.
3.  **Decision Making**:  Ideally the group would reach consensus.  Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote.  Discussed various options, including the role of the MHSA Steering Committee.  **Group decision**:  when it comes time to vote persons that have participated in at least 50% of the meetings will be allowed a vote.  Participants can send a designated alternate if they cannot attend a particular meeting; can contact Jerry (425-8785) or Linda Betts (454-4498) to let them know if you can't attend a meeting.
4.  **Resource Material**.  DMH gave outlines of various programs.  Reaction/Comments?  Can find out more information about programs by searching the web.  Note that some are specific to particular communities, so we would need to document that we've considered this.  Look at material as "models".  Discussed using logic model to figure out what we will use.   The group needs to decide upon its target population(s) and priority needs before deciding on model.  Jerry agreed, and said that models may stimulate our thinking; also, he will share models that other Counties are using for PEI programs.
5.  **Suicide Information**.  Local statistics were disseminated.  (Note:  these are not for publication.)  Brief discussion.  Noted that interventions need to be early, and need to teach children how to cope with stress and suicidal thoughts.
6.  **Defining Priority Population**.  Discussed the 5 proposed priority populations (Children and youth in stressed families; children/youth at risk of juvenile justice involvement; and after brief review/discussion narrowed the priority population for this group to Onset of Serious Mental Illness and to Trauma Exposed.  Long discussion regarding these 5 groupings, including the fact that they are inter-related (e.g. if you look at children at risk of school failure you may also be dealing with a child from a stressed family, and/or has suffered some kind of trauma, and/or is at risk of juvenile justice involvement, etc).  Discussion included:  school failure, expulsion & drop out problem (wanting to get more information about this problem comparing North and South County, and comparing cultural groups); disproportionate number of minorities being expelled; cultural factors that may impact these issues; how to serve gang involved, lgbt, Latino kids, foster and group home kids.  Also discussed onset of serious mental illness and use of drugs/alcohol.  Many think we need to involve family in services (though some kids may be already "differentiating" from their families).  Various questions considered:  what

type of service is needed? How much is needed? Where is the entry point? (Is the entry point the stressed family, or the child at risk?) Discussed using screening tools and agreed that this will not be helpful unless there are services we can refer to. Also talked about educational programs geared toward parents, teachers and school staff, to help them understand what mental illness looks like. Considered educating peers as well.

7. Group did not come to a decision about which group is the **priority population,** but considered the groups as related to each other as indicated below (either being a subset or connected to each other). Group will think about this and come back to this issue next time.

| Stressed Families | Onset of serious mental illness | Risk of school failure |
|---|---|---|
| Trauma | | Risk of juvenile justice involvement |

8. **Feedback about meeting**: Consider bring teens to meeting to give input (will consider this, but may hold off until we have more concrete ideas); appreciate keeping people "on track; would like a break in the middle to have a chance to network (this is not what the group agreed to, but will bring this back up next time as "old business"); appreciate people sharing their ideas as well as being open to others (this hasn't happened in some of the other groups); like the format and the facilitation is good.

**Next meeting**: Wednesday, July 30, 2008 from 9:30 to 11:30. 18 West Beach Street, Room 6, Watsonville, CA

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Jenny Sarmiento, Holly Heath, Bill McCabe, Nora Rahimian, Martine Watkins, Carly Galagneau, Denise Gannon, David True, Jaime Molina, Silvia Diaz, Ron Indra, Cecile Mills, Kathleen Kilpatric, Kaleo Kaluhima, Stuart Rosenstein, Shane Hill, Brenda Armstrong, Bonita Magnoni, Rita Martinico, and Yolanda Pérez-Logan.

1. Agenda was reviewed and accepted.  Jerry provided a recap of the workgroup's process. The MHSA Steering Committee has decided that a range of  $840,000 to $1,050,000 be used as a guideline for funding in the 0 to 25 age workgroups.
2. **Introductions:**  Jenny Sarmiento stated that she and Silvia Diaz might alternate in attending these meetings.
3. **Review of Priority Populations.**  Discussion about the overlap of the priority groups for this age group: Children and youth in stressed families, trauma exposed individuals and the onset of serious mental illness. Any one of these groups could be an "umbrella" for the others.  Some members of group spoke of 13 to 17 year olds as being autonomous and accessing services on their own; others agreed, but felt that they do better when their families are involved.  Group agreed that we should encourage family involvement. **Children/youth at risk of school failure.**  School failure is seen as a likely outcome of being within our three priority populations. The educational system rarely identifies or addresses the underlying causes of common indicators of school failure: drop in grades, attendance, suspension or expulsion. There are a disproportionate number of minority students that are suspended and expelled in the county.  There are systems in place to deal with these issues, but they are not adequate.
4. **Onset of serious mental illness**.  The group agreed to explore the precursors to serious mental illness and early indicators of the problem that families and primary providers might notice. Many cases in Santa Cruz precipitated by drug use.  Gaps in services exist (especially if person in not on Medi-Cal); this is problematic since early intervention may be more successful.  State exception to PEI:  services may be a bit longer for Onset than for other priority populations.
   a. **Who are the first to see persons with Onset of Serious Mental Illness?** Police, teachers, parents, relatives, school nurse, counselors, crisis line workers, friends, hospital staff, primary care providers, juvenile hall staff, foster care system employees, truancy workers, neighbors, housing authority staff, extra curricular activity employees, church-faith communities, employers.
   b. **What behaviors do persons with the onset of serious mental illness present?** Alcohol/drug/tobacco use, suicidal thoughts, risky sexual behavior, withdrawal, depression, violence/aggression, anxiety, self-harming, prostitution, isolation, truancy, socially inappropriate behavior, highly dependent, changed behavior, detention & warnings from school, DUI, public inebriation, frequent use of health services, runaway, pregnancy, being in violent relationship, stds, exploitation, bullying, signs of physical abuse, exclusion/left out/ostracized, body language,

loss of work, unusual thinking, journaling/art, obsessive, parents identify issues, self identified, over-achiever, changes in body weight, changes in sleep, parental divorce, homelessness.

5. **Children/youth in Stressed Families**
   a. **Who are the first to see Children/youth in Stressed Families?** Same as listed in #4a above. Added: family resource centers, children's protective services, homeless services, community based agencies that are family-oriented, unemployment agencies, family court, web-based social service providers, eligibility workers, immigration rights workers.
   b. **How do Children/youth in Stressed Families present? What do we see?** Similar to #4b above. Added: multiple families living together, atypical cultural response, poverty, underemployment, abandonment and neglect, language barriers, lack of housing, sexual/physical/emotional abuse, employment problems, lack of care giving adults, incarcerated youth or adult, divorce, blended families, sexualized family behavior, legal involvement, lgbt emergence, inability to get help, parents with serious mental illness, lack of parental authority/skills (especially regarding issues of stigma towards persons with serious mental illness, or homophobia), cultural clash, communication issues, chronic or catastrophic illness, out of home placement, denial of issues/problems, victims of crime.

6. The group noticed that some items identified are risk factors others are indicators of the problem. We need to consider what is easily measurable. The workgroup will continue to invite youth, ages 13 to 17, to the meetings and to conduct a focus group with them before we issue recommendations.

7. **Feedback on meeting**: Feeling antsy about not deciding the priority population before going on to brainstorm; need to go through a logic model process to decide priority population; some people have specific agenda and it would be good for people to re-state this; liked the brainstorming; interesting how diverse each work group is; wish meetings were at different times; appreciate having meetings in Watsonville; we came up with a great list; appreciate inclusive leadership; include SLV.

8. **Next Time**: Program presentation. Have people restate their "agenda". Jerry will separate the lists generated today into risk factors and those that are indicators of the problem. We will narrow the priority populations to be addressed and begin discussing outcomes for this group.

**Next meeting**: Wednesday, August 13, 2008 from 9:30 to 11:30. 1080 Emeline Avenue, Santa Cruz, Ca. (Meeting will be in the small auditorium in the basement of the Health Services Clinic.)

**Mental Health Services Act: Prevention & Early Intervention**
**Work Group:  Ages 13-17**
**August 13, 2008 meeting notes**

**Facilitator:** Dr. Jerry Solomon

**Attendees:** Adam Harrison, Aimée Mangan, Belinda Rubalcava, Carly Galarneau, Carol Williamson, Cecile Mills, Ginny Goméz, Holly Heath, Janet Seminerio, Javier Diaz, Jenny Sarmiento, Kaleo Kaluhiwa, Linda Betts, Martine Watkins, Mary Cross, Michael Paynter, Nora Rahimian, Pam Bartholomew, Ron Indra, and Vanessa Wilson

1. Agenda Review
2. All attendees shared introductions and personal agendas.
3. Old business
   a. Review of State DMH guidelines, funding allocation and the three age groups for Prevention & Early Intervention.
   b. Jerry reported on MHSA Steering Committee's guidance regarding workgroup funding:
      i.    0-25 age group, $840,000 - $1,050,000
      ii.   26-59 age group, $210,000 - $350,000
      iii.  60+ age group, $140,000 - $280,000
   c. **Priority groups** determined by each workgroup:

|         | Stressed Families | Trauma Exposed | Onset of Serious Mental Illness |
|---------|:-----------------:|:--------------:|:-------------------------------:|
| 0-5     | X                 | X              |                                 |
| 6-12    | X                 | X              | X                               |
| 13-17   | X                 | X              | X                               |
| 18-25   |                   | X              | X                               |
| 26-59   |                   | X              | X                               |
| 60+     |                   | X              | X                               |

   d. Three **evening meetings** for all workgroups have been added to the schedule:

| | |
|---|---|
| **August 19, 2008** (6:30-8:30 p.m.) 1080 Emeline Avenue (Large Auditorium) | "Trauma-Informed Services," presented by Gabriella Grant (the purpose is to expose everyone to evidence based practices). Q&A to follow. At the end, Dr. Jerry Solomon will lead the group to look at outcomes. |
| **August 26, 2008** (6:30-8:30 p.m.)  1080 Emeline Avenue (Large Auditorium) | "Onset of Mental Illness," presented by Dr. Charles Johnson, with a panel of consumers and family members to share what worked/what didn't. |
| **September 3, 2008** (7-8:30p.m.) 85 | "Stressed Families," presenter TBA. |

| Nielson St., Watsonville (Pajaro Valley Health Trust) | Jerry will lead the group to look at outcomes. |
|---|---|

4. The group brainstormed a Program Speaker List for the workgroup:
   a. Barrios Unidos
   b. Triangle Speakers
   c. Defensa de Meujeras
   d. Walnut Avenue Resource Center programs for boys and girls.
   e. PVSDSA
   f. Y.E.S. program
   g. Youth Services – Nuestro Futuro
   h. Green Body & Mind
   i. Stigma & Discrimination
   j. Suicide Prevention
   k. NAMI
   l. CRP – Youth in Probation
   m. United Advocates for Children/Families
   n. Protection & Advocacy
   o. Green Body Mind
5. Priority Populations
   a. Onset of serious mental illness
      i     (26) Exposure to violence
      ii    (24) Substance use/abuse
      iii   (12) Genetics
      iv    (11) Isolation
      v     (10) Nutrition
      vi    (7) Homelessness
      vii   (5) Bullying
      viii  (4) Sexual behavior
   b. Youth in Stressed Families
      i.    (26) Sexual/emotional/physical abuse
      ii.   (22) Economics: poverty, employment, housing
      iii.  (22) Criminal Justice involved families
      iv.   (20) Victims of crime/discrimination/stigma
      v.    (10) Divorce/loss
      vi.   (8) Parents with a mental illness
      vii.  (6) Emerging as a LGBT person
      viii. (5) Neglect and abandonment
   c. Trauma exposed youth
      i.    Gatekeepers
            1) Extracurricular programs
            2) Community leaders
            3) Peers/friends
      ii.   Risk Factors
            1) Parental distress
            2) Witnessing/involved with violence (domestic, abuse, gang, etc.)

3) Substance abusing parents
4) Family with mental illness
5) Incarcerated parents
6) Divorce/loss
7) Poverty
8) Immigration issues
9) Youth incarceration
10) LGBT emergence
11) Homelessness
12) Nutrition
13) Gang involvement
14) Lack of education/awareness of trauma involved practices by service providers
15) Stigma/discrimination
16) Oppression
17) Family history of suicide
18) Inept/wrong diagnosis of mental illness
19) Medication
20) Inadequate parenting skills
21) Difficult peer interactions
22) Difficulty with attention

iii. Indicators
1) Similar to Onset and Stressed families indicators
2) Inappropriate affect
3) Kids "under the radar"
4) Physical issues (sexual milestones, physical complaints)
5) Self harm
6) Self medicating

6. A draft of local mental health resources was shared with the workgroup and members were encouraged to send their comments and additions to either Alicia or Linda. Copies of the DMH document describing priority populations were distributed, as were definitions of common mental health terms and acronyms.

7. **Next steps** for the workgroup are to identify the top three risk factors for Trauma Exposed Youth; and begin to think about outcomes they'd like to see addressed by programs recommended by this group.

**Next meeting** will be on 8/27/08 from 9:30 a.m. – 11:30 a.m. at the United Way, located in the Begonia Shopping Center at 1220-C 41st Avenue, Capitola.

<u>**Mental Health Services Act:  Prevention & Early Intervention**</u>
**Work Group: Ages 13 - 17**
**August 27, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Martine Watkins, Stuart Rosenstein, Bonita Magnoni, Rita Martinico, Guy Grant, Emily Marsh, Belinda Rubalcava, Patricia Shroeder, Janet Seminerio, Pam Bartholomew, Ginny Gomez, Vanessa Wilson, Javier Diaz, and Yolanda Pérez-Logan.

1. Agenda review.
2. Introductions.
3. **Speakers**:  Stuart Rosenstein and Vanessa Wilson on the subject of LGBT services and issues in Santa Cruz County.  Stuart is from the Queer Youth Task Force (and they sponsor the Queer Youth Leadership Awards every year).  Services include the Gay Straight Alliances (GSA) which function like a club at several of the high schools (with strong programs at Watsonville High and Santa Cruz high); LGBT Task Force (which function on an ad hoc basis at PVUSD and Santa Cruz City Schools; Strange (at Youth Services); the Scene (at the Diversity Center); and Triangle Speakers (panel of people that speak about their lgbt/queer experience.   Law AB537 states that schools have to be safe, but some schools are not very welcoming (e.g. Triangle Speakers are not welcome at 2 schools).  There is a small number of youth that are being reached, based in large part because programs are not fully funded.  Issues for this age group include dealing with schools (from students to administrators) that are not queer friendly; coming out (even with "liberal" parents; suicide; homophobia & harassment; drug/alcohol issues; bullying; and homelessness (30% of homeless youth are queer).  Issue of bullying and homophobia also affects straight kids who are called names; it is especially problematic when youth complain to adults and nothing is done about it.  Suggestions for prevention include having support groups (not just social groups) that have licensed therapist facilitating them (e.g. a "coming out" support group), and trainings on queer issues required for teachers and staff at youth programs.
4. **Trauma Risk Factors**. Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
   a. Economics – poverty, homeless [11]
   b. Stigma, discrimination, oppression [2]
   c. Nutrition [5]
   d. Medication [3]
   e. Difficulty with peer interactions [2]
   f. Difficulty with attention [0]
   g. Family issues (mental health, substance abuse, history of suicide, child sexual abuse) [20]
   h. Parent issues – distress, inadequate parenting skills [5]
   i. Immigration issues [4]
   j. Incarceration of youth or parent [4]
   k. LGBT emergence [17]

l.  Gang involvement [4]

5.  **Recap from PEI "101": Universal Prevention:** risk free for everyone; low cost, desirable and accepted. **Selective Prevention:** targeted to high-risk groups; moderate costs; minimal effects. **Indicated Prevention:** targeted at high-risk individuals (showing signs, but not in the system), currently showing signs of a mental illness. **Early Intervention:** addresses early manifestation; low intensity/short duration; supports well being; avoid the need for more extensive/intensive mental health services; may include individual screening for potential mental health needs.

6.  **Brainstorm on possible outcomes.**
    a.  To increase high school graduate rates
    b.  To improve parent-child interactions
    c.  To train gate-keepers to recognize early signs
    d.  To decrease suicide risk in targeted group
    e.  To decrease family factors which put children at risk (immigrant families, kids at risk of suicide)
    f.  To improve parent-child relationships (in families with issues mentioned above, in LGBT)
    g.  To provide universal information/education regarding suicide prevention, substance abuse, domestic violence, child sexual abuse, lgbt.
    h.  To provide user-friendly information regarding mental health services for consumers, providers, and families.
    i.  To provide services to violence exposed targeted groups (child sexual abuse, children with incarcerated parents
    j.  To provide education and training regarding trauma exposed, lgbt emergence, suicide, and immigration issues.

7.  **Next Steps**: We will finish up desired out comes next time. Before next meeting review State Department of Mental Health Resource Guide. Link to PEI Resource Materials link: http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure6.pdf

**Next meeting**: Wednesday, September 10, 2008 from 9:30 to 11:30. Career Center, 18 West Beach Street, Room 2, Watsonville, Ca.

<u>**Mental Health Services Act:  Prevention & Early Intervention**</u>
**Work Group: Ages 13 - 17**
**September 10, 2008 meeting notes**

**Attendees:** Jerry Solomon (Facilitator), Linda Betts, Bonita Mugnani, Carly Galarneau, Cecile Mills, David True, Ginny Gómez, Guy Grant, Holly Heath, Jaime Molina, Janet Seminerio, Javier Diaz, Martine Watkins, Rocio Rodriguez, Silvia Diaz, and Yolanda Perez-Logan.

1. Agenda review.
2. Introductions.
3. **Program Speaker:**
   a. Carly Galarneau for "Suicide Prevention of the Central Coast." Serving Monterey, San Benito and Santa Cruz Counties for 40 years, we are a program of the Family Service Agency of the Central Coast. Services are across the lifespan, free, and confidential. Trained volunteers answer the crisis line 24/7 (with 60-80 volunteers working throughout the year). They are supported by 4 social workers. Two trainings are offered per year (40 hours) and everyone is asked for a one-year commitment at that time. We use the "language line" service that is an over the phone interpreter service, with 150 different languages available. There are approximately 200-450 calls received per month with most people calling because it is confidential and private. Follow-up is limited due to confidentiality. Calls can extend anywhere from 15 minutes to 3 hours with 90% of callers "de-escalated." We are integrated with some schools but it could be better. My wish is for more universal and gatekeeper training/resources in Santa Cruz County. That everyone would know about the crisis hot line (it be printed everywhere), and the community resources they can point you to.
4. **Priority Age Groups** given to Youth in Stressed Families and Onset of Serious Mental Illness. Will be collapsing the "youth at risk of failure in schools" and "youth at risk of legal system" with the 6-12 age group due to outcomes being almost identical. The "plan" will be written by county staff, based upon what we want to see as components/vision in the age appropriate services. The focus will be to look at existing organizations that offer services, let them know what we want and need, for the purpose leveraging.
5. **Focus Groups** will be conducted once we have concrete information to share and get their reactions. These meetings will be offered (by invitation) to those who will/would be using services and have not been able to attend workgroup meetings. They will be private and confidential. Contact with the groups we need to hear from will be made with organizations that have access to this population. Workgroups will reconvene to assess the information gathered from the focus groups.
6. **Training Academy** – Brief explanation of the Workforce, Education & Training plan (that includes the training academy) that was approved by the state and how it will provide trainings to the public health community. It is anticipated that many trainings will dovetail into some of the strategies discussed. (Community based organizations and consumers will be included as trainers where applicable.)

7. **Outcomes** – Discussion led to redefining some of the outcomes/strategies and adding strategies. Revised 13-17 Outcomes will be emailed to workgroup prior to next meeting. Crafted shared statements to include the 6-12 & 13-17 age groups.
    a. Outcome #1; delete <u>mental health.</u> Strategy #2; add the word; create a <u>position</u> that will be a system navigator…
    b. Outcome #2; define (youth in) <u>stressed families</u>. Strategy #1; Add <u>peer-to-peer</u> in the delivery of services. Bullet o: On-site services should be noted as "non-traditional," and in parentheses (i.e. Family Resource Center's).
    c. Outcome #3; Because the state has mandated we expand services to the underserved, and this group recognized LGBT and Latino youth as their priority groups, this language will not change. Add strategy; <u>Record trainings, i.e. Television/web cast/DVD.</u>
    d. Outcome #4; add "at risk of <u>suicide</u>." Strategy #1: Strategy #2: add, <u>and other venues</u>.
    e. Outcome #5, move to "System-wide" category. Include "<u>to dramatically increase suicide prevention for the 13-17 age group, and targeted gatekeepers on suicidality</u>."
8. **Evaluations** – Must be built into each program. At present, there are no programs that have hard data available. Can call out specifically where improvements are made (do have utilization data showing where the demand for services are). By evaluating programs annually, we will know whether to continue to re-fund them.
9. **Next steps** will be to refine the outcomes, look at targeted "priorities," and determine what kind of evaluation to build and what to measure.

**Next meeting**:  Wednesday, September 24, 2008 from 9:30 to 11:30.  United Way (Begonia Shopping Center) 1220-C 41st Avenue, Capitola.

**Attendees:** Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, Bill McCabe, Bonita Mugnani, Brenda Armstrong, Carly Galarneau, David True, Ginny Gómez, Guy Grant, Holly Heath, Jaime Molina, Janet Seminerio, Javier Diaz, Kaleo Kaluhiwa, Michael Paynter, Patricia Schroeder, and Yolanda Perez-Logan.

1. Agenda review
2. Introduction
3. **Program Speaker:**
   a. Javier Diaz and Ely Gonzalez for Community Restoration Program – working within the local community, providing programs dealing with youth (and some adults) having, i.e. drug, gang, school, issues, using strength based approach.  The first program is weekend work projects as an alternative to incarceration and to provide job skills. The second program is job training mentorship's (shadow/support) partnered with local businesses thru word of mouth and Watsonville newspapers. The third program, in collaboration with the County office of Education, is the Work Investment Act that is a 6-week orientation; covering work readiness ($150 stipend), job shadowing (4 times @ $25 each stipend), and work experience (200 hrs maximum). The fourth program is the Cal Group Program geared towards youth and young adults with gang issues (can participate if lower offense). This is an alternative to incarceration working for i.e. Habitat for Humanity, cleaning parks. The fifth program is, "REAL," Reforming Education Advocating for Leadership. Organized and run by youth, to discuss youth issues, work on community based projects/presentations and raise money for field trips. The primary issue of concern with this group is unhealthy relationships due to, i.e. Domestic Violence, Sexual Abuse, Teen Pregnancy, and Dating Violence. The goal is to provide a safe place for youth to meet (referred to as "youth circle"). Currently a, "Girl Space," group has been organized, facilitated by a woman. The need for a male youth circle has been recommended. There is no waiting list, serving all walk-ins and referrals from probation. The number one reason youth do utilize the services is to gain employment skills towards getting a job.
4. **Meeting Outcomes**
   a. Outcomes have been separated into three categories: Trauma-informed Services to Youth, Support to Stressed Families, and System-wide. (Practices have to be evidence based.) After review and discussion, the workgroup made the following changes:
      i. Outcome 1, delete "other marginalized youth." Delete "inadequate" and replace with "needing." The phrase, "youth/families needing parental skills, substance use/abuse issues, and/or exposure to violence, abuse and/or neglect," shall be used in place of "and other marginalized youth,"

throughout the recommendations. Strategy 3, delete "Create" and replace with "Identify" and add "school" after "support a."

    ii. Outcome 2, add strategy 2, "Service providers will be required to have been trained to provide "trauma-informed" services.

    iii. Outcome 4, delete

    iv. Outcome 5, add, "peers/youth and social services" to list of gatekeepers.

  b. This workgroup agreed that Outcome 5 then outcome 2 is their priorities.

5. **Next steps** will be to submit these recommendations to County staff. During the month of October, Focus Groups and Key Informant Interviews will be conducted to reach those who have not been able to participate in the planning process. Their responses/feelings will be included with the recommendations. County Staff will prepare the draft plan to submit to the Steering Committee (S.C.) on 10/27/08. In November, two "all-workgroup" meetings will convene to review the draft plan. County staff will do any changes needed to the draft plan. Once the final draft has been prepared using state language, a 30-Day Public Review will be posted in the newspaper and the public will be invited to comment on the draft plan at the Mental Health Board meeting (dates will be announced).

6. This workgroup has completed their recommendations. Thank you!

1. Introductions
2. Review of workgroup guidelines and rules
   a. We are to create and foster an integrated system
   b. The state has mandated that we use the Logic Model.
   c. Values and Guiding Principles
      i. Transformational programs and actions
      ii. Leveraging resources
      iii. Stigma and discrimination
      iv. Recognition of early signs
      v. Integrated and coordinated systems
      vi. Outcomes and effectiveness
      vii. Optimal point of investment
      viii. User friendly plans
      ix. Non-traditional settings
   d. The group will need to review its decision making model; we will try for consensus, and if unable to reach consensus use a majority vote to decide our recommendation.  The group needs to decide who can vote on the final decisions made to the Steering Committee.
3. Workgroup member's & agendas
   a. Jerry Solomon, Facilitator, Psychologist & MFT
   b. Carly Galarneau (Suicide Prevention Services alternating with Diane Brice). She is interested in funding for suicide prevention. She wishes to work on collaborations with other organizations.
   c. Lorraine Cahn (County of Santa Cruz, Program supervisor for Children's Mental health).  She would like to see what we could do to get jobs in the community for this age group. Does not think her agency will be applying for funds.
   d. Paula Comunelli (CEO, Listening Well, a person with a diagnosis and a community leader around mental health issues). She is working with various client leaders around the state to develop a summit meeting to create a system that works for everyone.  The new system would create shared leadership with consumers. By polling consumers involved with the Mental Health Client Action Network and Mariposa Center, she created a consumer priority list. The major priorities that consumer's felt needed to be addressed included: mental health advocacy, self-care, and meaningful work. She would like funding to support training facilitators to offer Listening Well events throughout the county in both English and Spanish.
   e. Richard Fairhurst (Parent of child with brain disorder). His motivation is to offer children with brain disorder more program options, have fewer holes in the system. He would like to offer education about these issues to all school levels.
   f. Adriana Guevara (County of Santa Cruz, Mental Health Client Specialist working with Transitional Age Youth).  She is trained as a social worker with bulk of experience in forensic mental health.  Transitional youth age range should be broadly defined.  My goal is to reach persons before their first break and let

people know where they can go to get services. Often young people with mental illness self-medicate with drugs and as a result you see the large majority of persons in jail or prison. She would like to develop a program that educates the community about resources and reduces stigma. Does not know if our agency will be applying for funds.

g. Chris Hogeland (County of Santa Cruz, program supervisor at the Homeless Persons Health Project). Many youth are not severely or chronically mentally ill at this point. But they are at great risk and could benefit from early intervention to prevent homelessness. Not here for funding, but would like to get other homeless providers here at the table to represent a link between homelessness and mental illness. Interested in creating employment programs.

h. Fred Koelher (CASA, Court Appointed Special Advocates). He sees transitional age from ages 15-25. We need to support the child after they "age out" of the system. Would be inclined to apply for funds, for training and supervision of the volunteers.

i. Susan Paradise (Nurse for Santa Cruz Community Connection). She is involved with two programs for transition age youth, Independent Living Program serving ages 15-21 and Transition Counseling serving ages 18-24. Believes that employment needs are very high; the self-esteem of youth goes up when they are employed. When the youth turns 18, the services they can access are dramatically reduced, during the time when, statistically, they will have their first break.

j. Carol Williamson (President of Santa Cruz Chapter of NAMI, parent of bi-polar child, and member of the MHSA Steering Committee). Families need so much help navigating the mental health system. Often problems emerge in high school; the parents know something is wrong but are afraid to tell the school, fearing they might encounter discrimination against their child and the stigma attached with labeling. There is a national provider education program that NAMI created that she would like to see implemented locally. NAMI's local family-to-family training program has a wait list because we do not have enough teachers. NAMI would like to apply for funds to offer provider education.

k. Denise Wyldbore (representative of COPA, Communities Operating for Empowerment and Action, has family member with Bi-Polar disease). She wants to coordinate with other people to put together youth programs within the Live Oak area including education for families and youth about where to access services. May be interested in funding.

l. Diana Carpenter (Manager of the Sexual Assault Dept. for the Women's Crisis Support). Nearly 85% of our clients are between the ages of 17-26 and are survivors of sexual assault. Would like to see more training for providers of transitional age youth about sexual assault and how to treat it. Particularly, a way to continue services after the 12 meetings we can offer. Also here as an advocate for LGBT youth. Not sure if agency will be applying for funds.

m. Charise Olson (County Office of Education, former coordinator of a youth employment program). If funding needs appropriate she would like to apply.

4. Planning Process
   a. Next step, pick a priority population
      i. Children/Youth in stressed families

      ii.   Children/Youth at risk of school failure
     iii.   Children/Youth at risk of juvenile justice involvement
     iv.   Trauma exposed
      v.   Experience onset of serious mental illness

   b.  State will offer its own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
   c.  The Steering Committee will establish funding ranges for each age group.
   d.  Program/s must be evidenced based with a built in evaluation component.
   e.  Need representation from stakeholders, as identified by the State
   f.  Identify missing stakeholders
      i.   Need Latino outreach
     ii.   African-American community outreach

5. Priority populations, per the DMH, to focus on in this workgroup
   a.  Trauma exposed
   b.  Individuals experiencing the onset of a serious mental illness
   c.  Children/Youth in stressed families
   d.  Children/Youth at risk for school failure
   e.  Children/Youth at risk of experiencing criminal juvenile justice involvement
   f.  Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.

6. Workgroup decisions to be made:
   a.  Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
   b.  Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.
   c.  Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
   d.  Required stakeholders include:
      i.   Education
     ii.   Consumers and/or their families
    iii.   Providers
     iv.   Health organizations
      v.   Social Services
     vi.   Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).
   e.  Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media

7. Review of MHSA PEI values and guiding principles.  All in attendance stated that they were aligned with these values and principles.

    a. Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.
   i. Leveraging resources
   ii. Stigma and discrimination reduction
   iii. Recognition of early signs
   iv. Integrated and coordinated systems
   v. Outcomes and effectiveness
   vi. Optimal point of investment
   vii. User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

**Next Meeting:** July 23: County Office of Education, 809 Bay Avenue, Capitola

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Ginny Gómez, Tara Fisher, Diana Carpenter, Susan Paradise, Charise Olson, Fred Koelher, Richard Fairhurst, Carol Sedar, Carol Williamson, Elisa Ramírez, Mariea Boisa, Diane Brice, Steve Ruzicka, Denise Wyldbore, Cecile Mills.

1. Agenda was reviewed.  No changes were made.
2. Introductions.
3. **Decision Making**:  Ideally the group would reach consensus.  Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote.  Discussed various options.  **Group decision**: when it comes time to vote persons that have participated in at least 33% of the meetings will be allowed a vote.  Participants can send a designated alternate if they cannot attend a particular meeting
4. **Stakeholders**.  Fact that meeting times are not posted at MHCAN and Mariposa Wellness Centers was brought up; Alicia informed the group that she spoke to directors of both sites and they agreed to post the meeting times.  Meeting times will be sent to all PEI workgroups, even though some meeting locations have not been secured.  As it is updated it will be sent out again to the workgroups; date on the bottom of page will indicate when it was last updated.  Work group members can disseminate the information about meeting times and locations to other interested stakeholders.  **Who is missing?**  Request that someone from UCSC or Cabrillo attend.  Diane Avelar (from Cabrillo) is a member of this work group, but absent today; Sara Peck (from Cabrillo) isn't back at work until mid August.  Will contact UCSC.  There are no transition age consumers, or consumers that began services when they were this age.  Steve Ruzicka will check with staff to see if one (or more) of their clients may want to participate.  Drug & alcohol rep is not present; Alicia will check will Bill Manov.  Some brainstorming about stakeholders; everyone to think about this and talk to others.  Discussed how not everyone can come to meetings; we can consider inviting guest speakers to one or more meetings.  Can consider doing a focus group and/or survey as well.
5. **Resource Material**.  DMH gave outlines of various programs.  Can find out more information about programs by searching the web.  Note that some are specific to particular communities, so we would need to document that we've considered this.  Look at material as "models".  Discussed using logic model to figure out what we will use.  Reaction/Comments?  Some people found the information confusing (e.g. TAY box was checked, but program described a different population); some felt like people are wanting to sell their programs; some programs feel like "deluxe" models, but we don't have a "deluxe budget".  Some felt like this was a good tool to spur some thinking.  Need to consider what services we do have in our community and what are the gaps.
6. **Defining Priority Population**.  Discussed the 5 proposed priority populations (Children and youth in stressed families; children/youth at risk of juvenile justice involvement; and after brief review/discussion narrowed the priority population for this group to Onset of

Serious Mental Illness and to Trauma Exposed.  There was much discussion about these five, including the overlap among them.  It was difficult decision, but group honed in on "onset of serious mental illness" and "trauma exposed individuals".  Did not have time to brainstorm about these two.  Next time we meet we will explore further what "trauma exposed individuals" means.

7. **Feedback about meeting:**  There was an appreciation for the different points of view and different voices in the group.  One person labeled it as "one of the most positive meetings" she has attended.  Another felt that while it was productive, it would be helpful to have handouts on the parameters of the program, information on trauma, and a directory of resources (which we will have next time).  May consider having potential clients at meeting as well.

**Next meeting**:  Wednesday, August 6, 2008 from 10 to 12 at CASA: 294 Green Valley Road, Suite 326, Watsonville, Ca.  This is in the old Watsonville hospital; enter where it says "The Towers".

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 18 - 25**
**August 6, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Tara Fisher, Diana Carpenter, Susan Paradise, Charise Olson, Fred Koelher, Richard Fairhurst, Carol Sedar, Carol Williamson, Mariea Boisa, Steve Ruzicka, Denise Wyldbore, Kathy Martínez, Bill Manov, Ivan Diamond, Chris Hogeland, Lorraine Cahn, and Dianne Avelar.

1. Brief update/overview on the process so far.
2. Introductions.
3. **Funding Guidelines**: The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only; not set in stone.
4. **Priority Populations for all groups** have been identified, as follows:
    a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    e. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    f. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
5. **Evening presentations/meetings announced.**
    a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
6. **Risk Factors: Onset of Serious Mental Illness.** Group brainstormed the following as risk factors for "onset":
    a. Substance Use
    b. Domestic violence
    c. Sexual abuse/abuse
    d. Isolation
    e. Homelessness

      f.   Genetics/family history

      g.  Failed relationships

      h.  Life transitions

      i.   Lack of support

      j.   Loss/death

      k.  Failure (dreams, school, work)

      l.   Different/discrimination/stigma

      m. Sexual orientation

      n.  Socio economic status

7. **Who are the first responders to persons with "onset"?** Group brainstormed the following:

      a.  Parents/family

      b.  Peers

      c.  Schools

      d.  Criminal justice, police

      e.  Counseling centers

      f.   Primary care providers

      g.  Family and children services, mandatory reporters

      h.  Emergency room

      i.   Employers

      j.   Bus drivers

      k.  Neighbors

      l.   Crisis lines, hotlines

      m. Dorm resident assistants (college)

      n.  Alcohol & drug treatment providers

      o.  Dominican Behavioral Health Unit

      p.  Communities of faith

      q.  Activity programs (sports, etc)

      r.   "The mall"

8. **Risk Factors for Trauma-Exposed individuals.** Group recognized that many of the risk factors noted above would be included here. Brainstorm by group came up with the following:

      a.  Substance Use

      b.  Domestic violence

      c.  Sexual abuse/abuse

      d.  Isolation

      e.  Homelessness

      f.   Failed relationships

      g.  Life transitions

      h.  Lack of support

      i.   Loss/death

      j.   Failure (dreams, school, work)

      k.  Different/discrimination/stigma

      l.   Sexual orientation

      m. Socio economic status

      n.  Addicted family member

   o. Leaving the foster care/youth care/initiation of contact with birth family
   p. War torn (multigenerational)
   q. Immigration issues
   r. Family gang involvement
   s. Parent with mental illness or chronic/catastrophic physical illness
   t. Person with mental illness or chronic/catastrophic physical illness
   u. Exposure to earlier trauma
   v. Cost of living in Santa Cruz
   w. Teen pregnancy
   x. Witnessing violence
   y. Victim of crime
   z. Peer pressure
   aa. Catastrophic events

9. **First Responders for Trauma-Exposed?** Will get to this item next time.

10. **Program Speakers?** Group had discussion about whom, if anyone, we would like to have come talk to the group. Idea is that since we don't want to create a whole new program it would be useful to have better idea of what services already exist for this age group. Ideas include: Barrios Unidos, UCSC and Cabrillo (regarding mental health services), NAMI, and a system overview, which could include County Mental Health (children and adult), COE (Charise), foster care (Susan P.). Group liked the idea of a system overview.

11. **To at our Next Meeting:** complete the first responders (for Trauma), do an exercise to hone in on the risk factors, have a program speaker. Jerry also encouraged everyone to attend the evening meetings (mentioned above).

12. **Feedback about meeting.** Comments (not exactly verbatim) included the following:
   a. "I like doing stuff, having an activity"
   b. "I like the windows, the natural light"
   c. "Thank you for the prodromal information you sent me; can you send research on 1st break research?" (Was referred to resource document and google site.)
   d. "I Appreciate the way you facilitate; you are always respectful"
   e. "This was confusing, especially the onset and trauma risk factors; it feels like we are moving slowly"
   f. "I appreciate the way you facilitate, always in control. It helps me relax."
   g. "I like that you convey information about what happens in other groups."
   h. "I appreciate everyone's voice".
   i. "I got confused. We said we were going to do just a brainstorm, but then began discussing things."
   j. "I don't want to lose sight of the first break issues."
   k. "The discussion between one and another (priority groups) didn't seem necessary."

**Next meeting**: Wednesday, August 20, 2008 from 10 a.m. to 12 p.m. at MHCAN, 1051 Cayuga Street, Santa Cruz, CA.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 18 - 25**
**August 20, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Tara Fisher, Charise Olson, Fred Koelher, Carol Sedar, Carol Williamson, Mariea Boisa, Chris Hogeland, Lorraine Cahn, Amy Daniels, Paula Communelli, Cecile Mills, Ginny Gomez, and Stephen Dubuous.

1. Introductions.
2. **Evening presentations/meetings** announced.
   a. **Tuesday, August 19th** from 7:00 p.m. to 9:00 p.m. we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento). Jerry Solomon engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals. There will be a follow training by Gabriella tentatively scheduled for Friday, October 24th from 10 a.m. to 3 p.m. Let Alicia or Linda Betts know if you did not attend sign up for this presentation and want to attend.
   b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
   c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
3. **Risk Factors for Trauma-Exposed individuals.** Group did a "dot" exercise to prioritize risk factors brain stormed at last meeting. Number in brackets indicates the number of votes:
   a. Family members- addiction, mental illness, violence, gangs, chronic illness, suicide history [24]
   b. Foster care – transitions, re-contacting birth family [15]
   c. Exposure to early trauma [10]
   d. Victim of violence/discrimination, stigma [23]
   e. Catastrophic events [0]
   f. Immigration issues [1]
   g. Teen pregnancy [0]
   h. Peer pressure [3]
   i. War exposed [0]
   j. Economics [3]

4. **Risk Factors: Onset of Serious Mental Illness** Group did a "dot" exercise to prioritize risk factors brain stormed at last meeting. Number in brackets indicates the number of votes:
   a. Substance Use/Abuse [21]
   b. Domestic violence [4]
   c. Abuse sexual/physical/emotional [14]
   d. Failed relationships – love/family [3]
   e. Isolation [4]
   f. Lack of support [7]
   g. Homelessness [7]
   h. Loss/death [0]
   i. Discrimination/stigma [1]
   j. Emerging lgbt [1]
   k. Economics [2]
   l. Failure (dreams, school, work) [4]
   m. Genetics/family history [10]

5. **Speakers:** Loraine Cahn and Cherise Olson spoke about the services they offer to transition age youth. **Lorraine** works in Children's Mental Health. Foster youth that are in "permanency planning" and are essentially being "raised by the system" are referred to the Supportive Adolescence Team comprised of mental health clinicians, social workers, independent living program (ILP) and transition housing program THP) staff. This team is staff by two county programs and Santa Cruz Community Counseling Center. ILP helps youth get jobs, obtain drivers license, get into school, etc. THP supplies vouchers to help youth obtain housing. **Charise** works for YEP (Youth Employment Program) to help foster youth obtain jobs, and works on whatever might be the obstacle to employment. Program serves youth age 14 to 21 and offers 200-hour internships, job shadowing, skill development, and guidance counseling focusing on work. Youth are referred by foster care (probation). **Mariea** shared that she works at Community Connection and that agency has family advocates, college connection, and career services for persons over age 18. They get funding from Department of Rehabilitation and provide guidance and work readiness services, help with job applications, have funds for interview clothes and serve persons with serious mental illness. **Lorraine** also shared that Jennifer Greco (also at Children's Mental Health) works with all 17 to 21 year olds in the system (they don't have to be in probation or social services). She helps link youth that need to move to "adult" transition team.

6. **Discussion about the services described above.** The challenge is that the capacity of the system is limited. Amy Daniels shared that she is a family advocate, and any one can call her for assistance (whether the person is in the "system" or not). Also discussed the need for better integration of services.

7. **Outcomes.** Outcomes can be system wide, by program or individual. Group brainstormed the following possible outcomes:
   a. To educate and train gate keepers regarding signs and symptoms
   b. To offer lgbt referral support and counseling
   c. To offer transitioning services to foster youth
   d. To provide education to potential consumers regarding early identification of symptoms

> e. To provide paid stipends and work crews (to persons at risk of mental illness)
> f. To offer transition age youth service that promote their life goals towards productive independence
> g. To create a system that integrates all transition age youth services with transferal and follow up
> h. To have a current resource guide available that is user friendly (phone and website)
> i. Peer outreach workers
> j. To support families of transition age youth
> k. To create a speakers bureau.

8. **Next Steps**: Group to review the transition age youth programs in the DMH Resource Guide; group to think about "given our priorities, what outcomes would we like to see?"


**Next meeting**:  Wednesday, September 3, 2008 from 10 a.m. to 12 p.m. at MHCAN, 1051 Cayuga Street, Santa Cruz, CA.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 18 - 25**
**September 3, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Carly Galarneau, Tara Fisher, Charise Olson, Fred Koelher, Carol Sedar, Carol Williamson, Mariea Boisa, Lorraine Cahn, Amy Daniels, Ginny Gomez, Susan Paradise, Bill Manov, Susan Paradise, Adriana Guevara, Diana Carpenter, Denise Wyldbore, Jesus Ramírez, Guy Grant, and Stephen Dubuous.

1. Agenda review.
2. Recap of previous meetings: onset of serious mental illness risk factors, trauma risk factors, review of prevention (universal, selective and indicated) and early intervention.
3. Introductions.
4. **Evening presentation/meeting announced. Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Dr. Rivka Greenberg.
5. **Outcomes.** Jerry handed out list of outcomes and strategies (see below). Discussion about what is already happening in the community, and what we can build on. It was pointed out that we want to do early intervention, and not just training to recognize signs and symptoms. Question came up about "first break"; the adult group will be focusing on first break, and therefore this group will not with the understanding that any first break program not be constrained by age of onset. Group decided that we need more direct services for 18 to 25 year olds. Elements of this would include:
   a. Increased capacity of counseling services to transition age youth (and their families)
   b. Low cost or free
   c. County wide
   d. Visibility (provide outreach to youth and gatekeepers)
   e. Peer to peer services, and professional, in non-traditional settings
   f. Case management "light"
   g. Advocacy/mentoring
   h. Access point of entry
   i. Psychiatric services
6. **Speaker:** Dr. Patrick Teverbaugh, County psychiatrist. Patrick used to be the doctor for the transition age team. He advises that if people get interested in life early on they are better functioning adults. He says that based on studies there is not much evidence that there is a way to delay or prevent onset of mental illness. He has seen that while medications can help that a big part of the treatment is the psychosocial realm (keeping an interest in school, keeping your mind active, engaging in social activities). Patrick thinks that outreach at schools, programs for drug/alcohol/tobacco use, and engagement (in exercise or socially) should not be seen as "extra". Work and job programs can also be helpful.
7. **Next Steps**: Think about model(s). What services do we want, what can we build on? We have just one or two meetings left.

**Next meeting**: Wednesday, September 17, 2008 from 10 a.m. to 12 p.m. at Career Services, 18 West Beach, room 2, Watsonville, CA.

Hand out on outcomes:

### Workgroup 18-25

To offer services that are culturally sensitive, trauma-informed and promote an independent and productive life for targeted TAY.

- Strategy: Train gatekeepers to (1) identify early signs and symptoms of mental illness and/or trauma exposure and (2) become familiar with services available to TAY.
- Strategy: Educate gatekeepers about unique cultural issues facing LGBT and Latino consumers.
- Strategy: Create a peer-to-peer mentoring program.
- Strategy: Require that programs reach out to LGBT youth.
- Strategy: Require services to TAY in foster care.
- Strategy: Provide paid stipends and work crew options to TAY at high risk of developing a mental illness.

To offer supportive services to family members of targeted TAY.

- Strategy: Involve the family early in treatment planning and offer them support services.
- Strategy: Offer peer-to-peer support groups.
- Strategy: Educate family about mental illness and the services available to the consumer.

To create an integrated/coordinated system to deliver TAY services.

- Strategy: Create a "TAY Service Council" to coordinate services
- Strategy: Create a system navigator position.
- Strategy: Create a user-friendly (consumer/provider) mental health resource website that is regularly updated.
- Strategy: Establish a 24-hour information and referral line.
- Strategy: Require all programs to build in client transferal mechanisms and well as follow-up protocols.
- Strategy: Create a Speakers Bureau

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, Bill Manov, Carly Galarneau, Carol Williamson, Diana Carpenter, Dianne Avelar, Fred Koelher, Guy Grant, Joanne Yablonksy, John Wright, Patrick Meyer, Lorraine Cahn, Steve Ruzicka, Tara Fisher, and Yana Jacobs

1. Agenda review.
2. Introductions.
3. Recap of previous meetings:  Priority population, Transition Age Youth - Trauma involved, and Onset of Serious Mental Illness.
4. **Speaker:**  Kelly Wolf, CASA (Court Appointed Special Advocates), designer and program manager for the "Independent Living Advocacy Program."  CASA serves 0-18 age youth, with 9 staff, and 150 Volunteers. Served 196 children in '06-'07, providing a voice for those taken under the protection of the juvenile court because of severe abuse and neglect by their family. The Independent Living Advocacy Program was designed to provide professional, volunteer advocacy for the older youth, transitioning out of the system. The goal is to support youth on their path to becoming healthy, successful, contributing young adults in the community. Incorporates three components: Independent Living Advocate (ILA) Role, staffed through volunteers, with 2-4 cases each working collaboratively with community partners to meet the youth's goals. Independent Living Consultants (ILC) is comprised of trained and professionally supported CASA advocates and community members, becoming the "expert" on resources and information one specific area (i.e. housing, education, employment…). ILA's and CASA's can contact particular ILC's when a youth's needs are identified. The third component is the "Peer Mentor," comprised of emancipated foster youth ("nothing about us without us"). With this program in place, mental health needs can be more readily addressed because the time a therapist has with these youth will not be spent advocating.
5. **Outcomes:**  Jerry compiled the outcomes and strategies into a one-page document for review by the workgroup members with emphasis on the three major outcomes: Educations (gatekeepers), System wide, and addressing direct counseling for psycho/social needs of TAY. This document was reviewed and edited as requested by the group.  See proposed project and strategies below.
6. **Gatekeepers:** Prioritized the list:
    a. Parents and families
    b. School staff, students, and programs
    c. Social service providers
    d. Health care professionals
7. Phone numbers as requested for the following:
    a. Women's Crisis Support: 831-425-4030 and 831-722-4532
    b. Parents Center: 831-426-7322 and 831-728-6445
    c. Suicide Prevention: 1-877-663-5433

8. This workgroup has completed their tasks. One more meeting will be held (tba) when the draft plan is ready for review.

## Prevention and Early Intervention for Transition Age Youth

**Proposed Project**: Coordination of the delivery of peer and professional support/counseling evidence-based services to transition age youth and their families in traditional and non-traditional settings. This program addresses transition age youth (persons ages 16-25) experiencing onset of serious mental illness, trauma-exposed individuals, and disparities in access to services.

**Strategy #1: To offer low cost/free client-centered mental health services to transition age youth that are culturally sensitive, trauma-informed, and promote an independent and productive life for TAY at risk of onset of mental illness, especially targeting the LGBT and Latino youth.**
- (Early intervention) Counseling services to TAY with special emphasis in foster care and alcohol/drug programs
- Assessment of psychosocial and drug/alcohol treatment needs with treatment planning/consumer goal statements
- Outreach programs to LGBT and Latino youth
- Peer-to-peer programs
- Advocacy
- Paid stipends and work crew options

**Outcomes**: Increased access to mental health services to at risk transition age youth.

**Evaluation:**

**Strategy #2: To offer mental health/support services to family members (or other support system) of targeted TAY.**
- Involve the family/support system early in treatment planning and offer them support services
- Offer peer-to-peer support groups
- Educate family about mental illness and the services available to the consumer and family

**Outcomes**: Increased mental health education and support to family members/support system of targeted TAY

**Evaluation:**

**Strategy #3: To provide training, technical assistance and consultation to gatekeepers serving targeted youth to help them identify youth at risk of suicidal behavior or serious mental illness, and how to effectively assist them in a culturally sensitive manner.**

Targeted gatekeepers are: parents/family/support system; school staff, students, and school programs; social service agencies; and health care providers.

- Training, technical assistance and consultation will include early intervention, how to clinically manage at risk transition age youth in diverse program settings, and how to adapt programs to better serve at risk transition age youth.
- Create a speakers bureau
- Educate gatekeepers about unique cultural issues facing LGBT and Latino consumers

**Outcome:** Targeted gatekeepers will demonstrate increased knowledge about the signs and symptoms of suicidal behavior and mental illness.

**Evaluation:**

Referral date from service agencies
Activity data on training and technical assistance and consultation contacts

**Mental Health Services Act:  Prevention & Early Intervention**
Work Group: Ages 26-59
**July 11, 2008 meeting notes**


Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Bill Manov, Donna Jacobs, Nina Stratton, Norma Paige, Kristie Clemens, Jim Brown, Karen Dawson, Bonnie Jay, Alexis may, Emily Marsh, Sandra Sandoval, Joanne.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Reviewed agenda.
2. **Introductions:**  People introduced themselves and their interest in participating in PEI (including whether they think their agency will want to seek funding).
   a. Jerry: facilitator, psychologist for 35 years, involved with various community-based agencies; would like to see a more rapid response to persons with mental illness.
   b. Nina:  a "highly employable" consumer; would like to see posttraumatic stress disorder (ptsd) be recognized, especially among Vets and homeless populations.
   c. Norma is a parent of two sons with mental illness, wants parents to be acknowledged for the work they do.
   d. Joanne works at Women's Crisis/Defensa de Mujeres; they have the only confidential shelter in Santa Cruz; helps women transition into work with drug/alcohol issues and/or mental illness; also interested in PTSD; does anticipate seeking funds; is also on the Women's Commission.
   e. Kristie:  Walnut Ave Women's Center; works with domestic violence issues, and also is a family resource center; PTSD.
   f. Jim: Diversity Center; wants to provide the voice and represent the LGBT community; not necessarily going to seek funding.
   g. Donna: Not This Time Vets, non-profit agency; Veteran's Services Advocate, and mother of a Marine; feels Veterans are not taken care of, and that they are truly the underserved; would like the County to provide mental health and physical health care; also working with law enforcement agencies to provide training regarding "alternative sentence law", and establishing a Veteran's ombudsmen; care of Veteran's needs to change, and hopes MHSA funding to help.
   h. Karen: Community Counseling Housing Support program; have about 135 clients, most are ages 26-59; have 1.5 clinical staff; half are doing well, other half do well at times, then go in hospital; need additional support.
   i. Bonnie: Community Support Services in El Dorado Center; working in the mental health field for 18 years; shocked to see El Dorado Center was to be cut by the budget crisis; wants to create a "sensory room" to help stabilize persons; does not want to see these programs cut.
   j. Alexis:  Suicide Prevention Services; provides community education and training as well as a 24 hour crisis line, and support for persons dealing with loss; wants to focus on integrated services to support people after the crisis; may apply for funds.

      k.  Emily: Suicide Prevention, new administrative coordinator.

      l.  Sandra: volunteer at the Diversity Center; information and referral call line staffed solely by volunteers, needs staff training; concerned about coordination of services.

      m.  Bill: County Alcohol/Drug services; provides funding for community based agencies providing alcohol/drug services in Santa Cruz; interested in both youth and adult services; adult mental health system only deals with persons with serious mental health issues; haven't had the resources to provide adequate mental health services for person's with alcohol/drug issues and less chronic mental health issues.

      n.  Alicia: MHSA Coordinator, Program Manager, 25 years experience in a variety settings and different populations; wants to ensure we have a good process and get stakeholder input, and adhere to State DMH guidelines.

      o.  **Comments?** There is a great need, and many ideas, however the "pot" of money is pretty small, so our challenge is to focus on what would be most helpful in our County.

      p.  **Appeals?** There is no formal appeals process for the plan, but the workgroups will work on their portion of the plan and will forward their recommendations to the MHSA Steering Committee who is responsible for final approval. Plan will undergo 30-day review and anyone in the community can comment on the plan; after review we send the plan to the DMH for their approval and funding. We do not have to go to the Board of Supervisors prior to submitting our plan to DMH.

      q.  **Target population?** Each priority population called out by the State is as important as the other. One member commented that Vets are especially in need of services, and the their whole family is affected. Jerry commented that most of the work groups have identified stressed families is a group that needs services. **WRAP** (Wellness Recovery Action Plan) is a possible tool useful to stressed families, and that is has been tailored to serve the lgbt and veterans community.

3.  **Ground Rules** reviewed.

4.  **Decision-making**. Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may attend only when it is time to vote. The group decided that when it comes time to vote persons that have participated in at least 50% of the meetings will be allowed a vote. Participants can send a designated alternate if they cannot attend a particular meeting; can contact Jerry (425-8785) or Linda Betts (454-4498) to let them know if you can't attend a meeting.

5.  **Leveraging.** State would like us to leverage our PEI programs, and this can include in-kind services, administrative costs, or site.

6.  **Stigma and Discrimination (regarding serious mental illness) and Suicide Prevention** are two overarching concerns. DMH will offer statewide programs; may do this by offering additional funds for Counties to do these programs. Goal for PEI is to recognize early signs of mental illness. Also DMH wants counties to have integrated services to ensure connection to referral sources. PEI is an outcome driven program; we will need to evaluate the programs we develop. The challenge is proving something didn't happen. Will also need to consider offering services in non-traditional settings.

7. **Priority Population?**  We need to consider which is our priority population (trauma exposed individuals, children/youth in stressed families, children/youth at risk of school failure, children/youth at risk of juvenile justice involvement, and/or onset of serious mental illness
8. **Resource Map.**  It would be helpful to know what services are available for this age group.  Where are the gaps in services?
9. **Stakeholders.**  Who is missing? We can offer focus groups, or key informant interviews if stakeholders can't attend ongoing meetings. Underserved communities (e.g. Latinos), Education (perhaps consider Sara Peck from Cabrillo), health providers (get input from Homeless Persons Health Project, Salud Para La Gente, Planned Parenthood); law enforcement (Officer Seelig, Christine Swannick, Tony Jack).  Consider also involving family resource centers, employment and media.  Call Jerry with any names of possible stakeholders and he'll invite them to our meetings.
10. **Next Steps.**  Review the ASR report, and review the resource guide provided by DMH.
11. **Review of Meeting.**  Jerry felt he talked too much, and hopes future meetings will be more interactive.  People appreciated the integrity of the process, and Jerry's easy manner of communicating.  Concern expressed about PEI 101 being repeated again (Jerry said that this is the last overview), and there is "skimpy" information for the 25-59 year old group.  There was appreciation for the focus of the meeting, and a hope that people that come to the meeting are open to others' concerns.


**Next meeting**:  Friday, July 25, 2008, Ag Extension (behind old court house in the corner of the parking lot), 1432 Freedom Blvd, Watsonville

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 26 to 59**
**July 25, 2008 meeting notes**

**Attendees:** Bill Manov, Emily Marsh, Kristie Clemens, Darrie Gawhorn, Nancy Kael, Will O'Sullivan, Karen Dawson, Jim Brown, Norma Paige, Art Anton, Joanne de los Reyes, Bonita Mugnani, Alicia Nájera, Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Decision Making**: Consensus is the ideal, but we may need to vote on a decision. Who is allowed to vote? Various ideas were proposed. Group decided that persons need to have attended 50% of the time and attended 3 of the last 5 meetings. People may designate a proxy to vote, if they cannot attend. Will not restrict one agency to one vote, especially if they are representing different programs (e.g., Santa Cruz Community Counseling Center).
4. **DMH Resource Guide**. Programs should be evidence based. State has loosened their stance on this, but we will still need to evaluate programs. Need to use logic model; can use Resources as a model. As other Counties submit their Plans we will review and see if there is anything of interest to us, and share with the workgroups.
5. **Priority Populations**. Discussed the five groups, and decided to narrow our focus to Trauma Exposed Individuals and to Onset of Serious Mental Illness. What do these two mean for this work group?
6. **Trauma Exposed Individuals**. Veterans; incest/sex abuse survivors; domestic violence (repercussions of the trauma can lead to alcohol or drug use, mental illness, post traumatic stress disorder); homelessness; onset of mental illness can lead to trauma; trauma and substance abuse are co-indicated, as are depression and suicide. Also touched on these issues: don't want to duplicate services, want to deal with the underserved, and want to look at holistic, integrated approach. Refer to page 14 of the State Department of Mental Health Resource list to see how they describe "trauma exposed".
7. **Who are the trauma-exposed individuals**? Veterans, persons coming out, persons that have alcohol/drug dependence, survivors of dysfunctional families, incarcerated, or were incarcerated, untreated mental illness, homeless. Also, victims of: job loss, domestic violence, sexual assault, child sexual abuse, racism, hate crimes, discrimination, violence, harassment, natural disasters.
8. **Where do trauma exposed individuals show up**? Emergency room, diversity center, detox center, substance abuse centers, homeless services center, jail, the streets, survivors healing center.
9. **Who are the trauma-exposed individuals we don't see**? People who do not report, isolated, fearful, hiding (don't feel it is safe), don't identify as having a problem (domestic violence, alcohol or drug abuse), feel stigmatized, undocumented, had a bad experience in the past when tried to get services, in the closet, "protected" by their role (priest, teacher, coaches).
10. **Who are at risk of suicide**? LGBT, substance abusers, injured workers (even though workers comp is supposed to serve them – it often fails), isolated and move to despair.

11. **Reaction to meeting**: Facilitation was great; feel overwhelmed; put notes on board; great to see we're getting into it now. We should do a brainstorm for "onset to serious mental illness", like we did for trauma exposed.

**Next Meeting:** Friday, August 8, 2008. From 9:30 to 11:30 at Community Counseling Center, 195 Harvey West, Santa Cruz, Ca. (In the back.)

**Mental Health Services Act: Prevention & Early Intervention**
<span style="color:blue">**Work Group:  Ages 26 to 59**</span>
**August 8, 2008 meeting notes**

**Attendees:** Emily Marsh (Suicide Prevention), Kristie Clemens (Walnut Avenue Women's Center), Darrie Ganzhorn (Homeless Person's Garden Project), Will O'Sullivan (Santa Cruz Community Counseling Center), Karen Dawson (SCCCC- mental health housing), Sandra Sandoval (for Jim Brown) (Diversity Center), Norma Paige (NAMI, family member), Joanne de los Reyes (Defensa de Mujeres/Women's Crisis), Bonita Magnani (Survivors Healing Center), Pam Barthalemew (MHCAN, consumer), Dorian Seamster (Safety Clinics), Bonnie Jay (El Dorado Center), Carol Williamson (NAMI), Betsy Clark (SCCCC), John Wright (Counseling Center, and Mariposa), Cecile Mills (educator and consumer), Rocio Mendoza (consumer), Alicia Nájera (MHSA Coordinator), and Jerry Solomon (consultant/facilitator).

1. Introductions.  People also stated the agency/group they represent; several hoped to receive funding from the PEI programs.
2. **Funding Guidelines**:  The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000.  These amounts are guidelines only; not set in stone.
3. **Priority Populations for all groups** have been identified, as follows:
    a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
    b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
    d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    e. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
    f. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
4. Evening presentations/meetings announced.
    a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
    b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz.  We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes.  Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
    c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
5. **Trauma-Exposed Individuals.**  Recap of last meeting.
6. **Risk Factors**: (group added k-l)

      a.  Veterans [5]
      b.  Survivors of sexual abuse [14]
      c.  Domestic violence [10]
      d.  Homeless [10]
      e.  LGBT (coming out) [5]
      f.  Substance dependence [8]
      g.  Incarcerated [5]
      h.  Untreated mentally ill [16]
      i.  Victims of discrimination [4]
      j.  Violence/hate crimes [3]
      k.  Diagnosed as mentally ill [12]
      l.  Immigrants [4]

7. **First Responders**: (group added i-s)
      a.  Emergency Room
      b.  Diversity center
      c.  Detox center
      d.  Substance abuse programs
      e.  Homeless services
      f.  Jail
      g.  The streets
      h.  Survivor's Healing Center
      i.  Parents/family
      j.  School teachers/counselors
      k.  Mental health programs
      l.  Dominican Behavioral Health Unit
      m. Police
      n.  EMT (1st response)
      o.  Family resource centers
      p.  Crisis line
      q.  Primary care providers
      r.  General public
      s.  Faith based communities

8. **Trauma: Risk Factors Exercise.** Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors. The risk factors that got the most votes (noted in brackets above) were: survivors of sexual abuse, domestic violence, homeless, untreated mentally ill, and diagnosed as mentally ill. Group discussion of the results. Noted that some risk factors may be subsets of other risk factors.

9. **Onset of Serious Mental Illness.** Group did brain storm of risk factors: genetics, nutrition, lack of support, stress, lack of education, low socio-economic status, substance use/abuse, "just folks", family trauma, exposure to physical/sexual/emotional abuse, loss (death, divorce, foreclosure of home), isolation, victim of crime, racism, discrimination, military, predisposition. Discussion during the brainstorm included the need to look at risk factors at earlier age groups and intervene earlier. Group talked about possibility of

having a program for "first breaks", which could include alternatives to hospitalization, and support for person/family while going through this experience.

10. **Resources.** Draft resource list was handed out. Group asked to review, add or edit information to keep this up to date.

11. **Program speakers?** Group made list of possible speakers to come to this work group to do a 10-15 minute presentation. List included: Delphine Brody, Dr. Pat Teverbaugh, Ms. Mariposa –acupuncture. At September 9th meeting Women's Crisis Support/Defensa de Mujeres, Walnut Avenue Women's Center, and Survivor's Healing Center will do presentation about their services.

12. **Next Steps.** Need to review resource guide; attend the evening meetings; will finish up risk factors.

13. **Reaction to meeting**: Liked getting up and moving around; it is hard to sit for two hours!


**Next Meeting:** Friday, August 22, 2008. From 9:30 to 11:30 at United Way (in the Begonia Shopping Center.) 1220-C 41st Avenue, Capitola.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 26 to 59**
**August 22, 2008 meeting notes**

Attendees: Emily Marsh, Darrie Ganzhorn, Jim Brown, Norma Paige, Joanne de los Reyes-Hilario, Betsy Clark, Cecile Mills, Rocio Mendoza, Guy Grant, Bill Manov, Carly Galarneau, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. Evening **presentations/meetings** announced.
   a. **Tuesday, August 19th** we had a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engaged the audience to gather input on desired outcomes for Trauma-Exposed individuals.
   b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes. Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
   c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
4. **Speaker: Bill Manov.** Spoke about drug and alcohol services in Santa Cruz County and handed our resource referral directory. The County does provide some assessment, referral and case management, but actually provides very little direct services; the County contracts with community based agencies for direct services. Funding resources include Medi-Cal, Prop 36, and some "discretionary" funds. Funds have decreased over the years; used to pay for 6-8 months of residential treatment, and not the maximum is 2-3 months with a step down to sober living environment plus case management. Have a trained clerical person that can answer referral line (454-4050) from Monday thru Friday from 8 a.m. to 5 p.m. One big issue that Bill sees is that persons that have substance use problems are often dually diagnosed, but do not qualify for County Mental Health because their mental health issue is not a "serious mental illness". Vision is to have a strong mental health dual diagnosis treatment program, with training and consultation to drug & alcohol staff, psychiatric support (to assess and treat), and to provide support for medications.
5. **Onset of Mental Illness**. Group did "sticky dot" exercise. Each person got 6 "sticky dots" and was able to mark the risk factor that they thought was most serious; each person could put up to three dots on one risk factor, put had to put the rest on other factors.
   a. **Risk Factors**:
      i.    Genetic predisposition [1]
      ii.   Lack of support/isolation [6]

        iii.     Substance abuse/use [14]
        iv.     Exposure to crime [3]
        v.     Military exposure [9]
        vi.     Discrimination/racism/stigma [2]
        vii.     Loss/divorce [0]
        viii.     Abuse – physical/sexual/emotional [9]
        ix.     Nutrition [3]
        x.     Stress [0]
        xi.     Economics [3]
        xii.     Family history of suicide and/or mental illness [10]

6. **Wrap up:** Work groups will warp up by the end of September. We need to come up with outcomes and proposed programs. We will have MHSA Steering Committee look at proposals, and will be doing focus groups also. Need to have work groups look at resource guide to think about proposed programs.

7. **Outcomes:** First Break. Group brain stormed possible outcomes, including:
   a. To provide early identification of serious mental illness
   b. To improve global assessment of functioning by early treatment
   c. To enhance resilience and protective factors
   d. To promote social support, recovery, and academic achievement and/or employment
   e. To decrease hospitalizations, involvement with criminal justice, drop outs
   f. To decrease loss of housing
   g. To promote diversion for greater use of mental health resources/intensity by providing early assessment and intervention
   h. 80% of persons who request services receive assistance

8. **Next Steps:** Think about outcomes. Explore programs to achieve outcomes, and think about measurable outcomes for evaluation.

**Next Meeting:** Friday, September 5, 2008. From 9:30 to 11:30 at Career Center, 18 West Beach Street, Watsonville, CA.

Attendees: Emily Marsh, Norma Paige, Joanne de los Reyes-Hilario, Cecile Mills, Guy Grant, Carly Galarneau, Kristie Clemens, Bonita Magnani, Carol Williamson, Carol Sedar, Pam Bartholomew, John Wright, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Speakers:  Kristie Clemens** (Walnut Avenue Women's Center)**, Joanne de los Reyes-Hilario** (Women's Crisis/Defensa de Mujeres) and **Bonita Magnani** (Survivors' Healing Center).  Each person presented their agency and the work that they do.  **Walnut Avenue Women's Center**:  supportive services to women and children; early childhood education; teenage parent program; toddle center; community education (helping youth make health choices and have healthy relationships); domestic violence programs (including 24 hour hotline, groups for parents, groups for kids, and individual counseling); and have 3 "safe homes".  **Women's Crisis/Defensa de Mujeres**:  crisis intervention; 24 hour crisis line; services to domestic violence and sexual assault victims; help with restraining orders; go to court, police or district attorney's office with clients; have drop-in counseling groups; have shelter for women in immediate danger; offer 8 week family workshop (for parents and group for kids); work with youth that have witnessed domestic violence, including teen support group.  **Survivors' Healing Center**: small agency (only 3 staff) that serves youth and adult child sexual abuse victims; offer extensive therapy groups; serve men, women, LGBT, Latinos.  **All three agencies:**  work together and often refer to each other.
4. **Outcomes:  Onset of Serious Mental Illness (& First Break).**  Discussion about the proposed projects the group has come up with.  Group wants to make sure we state that these are to be client-centered services.  Projects fall into two main categories: onset of serious mental illness (which includes ptsd), and first break.
    a. To promote early detection of serious mental illness (in a stigma neutral fashion).
        i. Strategy:
            1) Train gatekeepers in early signs and symptoms of mental illness, suicidality, trauma-exposed youth, and how to make effective, helpful referrals.
        ii. Evaluation:
            1) Utilization data
            2) Consumer goal achievement measures
            3) Consumer satisfaction measures
            4) Global Assessment of Functioning
    b. To provide comprehensive client-centered services to those of all ages experiencing or at risk of experiencing a psychotic break.
        i. Strategy
            1) To offer evidence-based treatment (EPPIC?) to treat the primary signs and symptoms of psychotic disorders and provide on-going recovery services for (up to two years).

        2) To engage family members early in the treatment process and enlist them as allies in assisting the consumer.

    ii. Evaluation:
   1) Decrease the use of the Behavioral Health Unit
   2) Decrease the use of emergency room services
   3) Decrease in the loss of work/school/family time
   4) Completion of a WRAP plan
   5) Improved Global Assessment of Functioning (GAF)

  c. To provide a program that enhances resilience and protective factors for those identified as "at risk" for developing serious mental illness.

    i. Strategy:
   1) Offer professional and peer-to-peer psycho-educational and recovery services

    ii. Evaluation:
   1) Utilization data
   2) Consumer goal achievement measures
   3) Consumer satisfaction measures
   4) Global Assessment of Functioning

5. **Client Outcomes:** Group reviewed the above and brainstormed more outcomes: avoid hospitalization; return to life activities (work, school, maintain housing); self sufficient/functioning; mental health education (to understand diagnosis); to expose person to persons that are successful in their recovery; WRAP; safety; to having a neighborhood advocate; to create safe place, supportive environment to address isolation; to have an easy, rapid access for social/economic needs; decrease distress; increase functioning.

**LAST MEETING:** Friday, September 19, 2008. From 9:30 to 11:30 at the Diversity Center, 1117 Soquel Avenue, Santa Cruz, Ca.

<u>**Mental Health Services Act: Prevention & Early Intervention**</u>
**Work Group: Ages 26 to 59**
**September 19, 2008 meeting notes**

Attendees: Emily Marsh, Norma Paige, Joanne de los Reyes-Hilario, Guy Grant, Carly Galarneau, Kristie Clemens, Bonita Magnani, Carol Sedar, John Wright, Bill Manov, Jim Brown, Betsy Clark, Karen Dawson, Will O'Sullivan, Darrie Ganzhorn, Yana Jacobs, Alicia Nájera, and Jerry Solomon.

1. Agenda Review.
2. Introductions.
3. **Speakers: Chris López (with Jordan Harding)** from the Veteran's Center on 41st Avenue, Capitola. Chris is the outreach worker for the Veteran's Center, and is a medically retired Veteran himself after being wounded in Bagdad. Chris described the mental health services available at the Capitola site. Staff includes LCSWs, MFTs, and psychologists. These are outpatient services, and they specialize in PTSD. Services are free for combat veterans (or sexually traumatized veterans), and their families. Combat veterans are persons serving in a war zone for 30 days. The Veterans Center has a free shuttle to the Palo Alto Veterans clinic, and they are going to get a motor home to do outreach. Chris spends a significant amount of time at Camp Roberts engaging persons as they are discharged. Chris encourages all Veterans to get registered to get service connected, even if they don't see any problems when they first come home. Chris can be reached at 588-9865 if further information is needed.
4. **Carol Sedar** read some quotes about serious mental illness and spoke about the importance of remembering the focus of this work group.
5. **Reviewed the Outcomes** for this group. After discussion group decided Outcome #1, is the priority of the group, while stressing the importance of #2. (The group actually wants both of these to be funded). Targeted gatekeepers are: Social Services (including Diversity Center, detox centers, substance abuse services, veterans services, family resource centers, mental health and domestic violence programs, homeless programs); educators (teachers and counselors); and emergency services (including police, jail, and primary care providers). The group came up with the following:
   a. <u>Outcome 1:</u> To provide comprehensive client-centered services to those of all ages experiencing or at risk of experiencing a psychotic break.
      i. Strategy
         1) To offer evidence-based treatment (EPPIC?) to treat the primary signs and symptoms of psychotic disorders and provide on-going recovery services for up to two years. This program shall:
            - Engage family members early in the treatment process and enlist them as allies in assisting the consumer.
            - Offer a peer-to-peer program for exposure to persons that are successful in their recovery and can serve as mental health advocates for consumers.
            - Offer a program that enhances resilience and protective factors for those identified as "at risk" for developing serious mental illness.

        ii. Evaluation
  1) Decrease the use of the Behavioral Health Unit
  2) Decrease the use of emergency room services
  3) Decrease in the loss of work/school/family time
  4) Completion of a WRAP plan
  5) Improved Global Assessment of Functioning (GAF)
  6) Utilization data
  7) Consumer goal achievement measures
  8) Consumer satisfaction measures
  9) Global Assessment of Functioning

b. Outcome 2: To promote early detection of serious mental illness or risk for suicidal behavior in a stigma-sensitive fashion.
  i. Strategy
   1) Provide training, consultation, and technical assistance to targeted gatekeepers in early signs and symptoms of mental illness and the warning signs for suicidal behavior. Train targeted gatekeepers on strategies to effectively assist individuals at risk of serious mental illness or suicidal behavior, including how to make appropriate and helpful referrals.
  ii. Evaluation
   1) Utilization data
   2) Gatekeeper referrals to service agencies

1. Introductions
2. **Review** of workgroup guidelines and rules
   a. We are to create and foster an integrated system
   b. The state has mandated that we use the Logic Model (will need to document that we are doing this and the State will evaluate us).
   c. Values and Guiding Principles
      i. Transformational programs and actions
      ii. Leveraging resources
      iii. Stigma and discrimination
      iv. Recognition of early signs
      v. Integrated and coordinated systems
      vi. Outcomes and effectiveness
      vii. Optimal point of investment
      viii. User friendly plans
      ix. Non-traditional settings.
   d. Will need to come back to the decision making model; will try for consensus, then go to majority, however there are times when there is a very hot issue with people who have never attended the meetings, will all of a sudden attend and everybody votes in a certain direction. So the issue of honoring the process is that we need to decide how we will proceed if we run into this situation.
3. **Workgroup member's & agendas**
   a. Jerry Solomon, Facilitator, Psychologist & MFT
   b. Francie Newfield (Human Services Dept., Mgr of Adult Protection Services, support MSSP: Multi-Purpose Senior Services Program) The MSSP is reverting back to the state and requires an RFP/Contract award to continue. Committed to continuing services. Aware of the need to have mental health services around issues of depression and isolation, and the need to have a differential diagnostic process for people who are showing sudden signs of psychosis (which sometimes are related to dementia and sometimes not). To include support for the caregivers. Come up with a better screening program for places we want to refer people to.
   c. Rita Flores (Asst. Agency Dir., Family Services Center), involved with the Senior Outreach Program, believe peer counseling is the way for seniors; if you take a young therapist of 25 to deal with a senior there is no connection. Excellent model for this age group. Work together with other groups and bring peer counseling to them.
   d. Cecile Mills (Education, Instructional Development, Publishing, Training and sits on the MHSA Steering Committee). Interested in evaluation (the county needs to have information to determine what works with people, if they have evidence for it) and concerned people slip thru the cracks in this system. Need for good measurement and evaluation and outcomes of what's happening to people in the system.
   e. Linda Robinson (Advocacy Inc., Coordinator for Long Term Care Ombudsman program). Work with seniors; want to see more services to people living in long-

term care facilities. They have social workers but they are not capable of dealing with issues of depression. Quality of life has declined in these settings. Many seniors on medi-cal cannot get here for services. Would like to see an outreach program.

f. Steve Ruzicka (Supervisor for Older Adult Team at the County Mental Health). Here to get a sense of the needs of the greater community, what is needed, with the hopes of expanding the team (currently 2 staff). Getting a new Psychiatrist specializing in gerontology in August.

g. Ann Pomper (Director for Hospice of Santa Cruz County & worked with Santa Cruz Community Counseling Center for many years). Not interested in the funds, interested in knowing what's going on and us connecting. Last year served over 800 people who were dying; 80% are seniors. Need to engage well with rest of community, making connections, and need to know what's going on. Believe Hospice is at risk at the federal level and wants the community know so they can be championed. Building advocacy and letting you know what Hospice has in terms of end of life services and education so that everyone has access to these services.

h. Laura Orick (Shelter Manager for Women's Crisis Support). They serve women in this age group but it is a small proportion of clientele. Here to learn more about services in the community. Learn about the process. Not interested in any funding.

i. Betsy Clark (Mgr of Adult Programs for the Santa Cruz Community Counseling Center & sit on the MHSA Steering Committee.). Not interested in trying to create a program or bolster up a program. Interested in learning more about the services that are available in the community. Even for people who are treated for serious mental illness, things change, as they get older. In addition to physical problems there is more isolation and there are fewer choices for people.

j. Clay Kempf (Executive Director of the Seniors Council). His agency creates an area plan for seniors under the auspices of the Older American Act. Mental Health, especially loneliness, depression, & isolation has risen in surveys we have done in the past, as a higher priority need then seen previously. I am here to make sure existing community programs get support and are integrated into existing services. Not looking for funding.

k. Jane Schwicherath Has a Master's Degree with a specialty in aging and earned a Gerontology Certificate. Is current regarding research on LGBT (Lesbian, Gay, Bisexual & Transgender) aging issues. Here not to create a program or try and get funding but to champion for the LGBT senior. The depression and isolation for LGBT seniors is much more than for others. They grew up in a time when it was illegal, immoral and could be locked away for being gay. There is tremendous fear in this group to even be out. Most LGBT seniors go back into the closet when they need services. Expanding to do education and LGBT cultural competency within skilled nursing facilities and assisted living facilities, to improve the education and understanding.

l. Chris DiMaio (Retired Psychiatrist and Combat Vietnam Vet). Not here for the money. Representing the Diversity Center, specifically the "Rainbow Vet" organization that was formed to address the needs of gay veterans, many who do

not feel completely welcome in either the gay or Veterans community and frequently feel isolated, with no social outlets. There are many veterans in Santa Cruz who have never talked with other gay veterans, particularly with Latina and Latino Vets. One thing we see as important is to have someone to coordinate services for veterans, and coordination for services for the families. Outreach services are needed.

4. **Planning Process**
   a. Next step, pick a priority population
      i. Children/Youth in stressed families
      ii. Children/Youth at risk of school failure
      iii. Children/Youth at risk of juvenile justice involvement
      iv. Trauma exposed
      v. Experience onset of serious mental illness
   b. State will do own initiative on Suicide Prevention and Stigma reduction of the mentally ill.
   c. Steering Committee will set funding percentage
   d. Program/s must be evidenced based with an evaluation component built in
   e. Need representation from stakeholders, as identified by the State
   f. Identify missing stakeholders
      i. Need Latino outreach
      ii. African-American community outreach

5. **Priority populations**, per the DMH, to focus on in this workgroup
   a. Trauma exposed
   b. Individuals experiencing the onset of a serious mental illness
   c. Children/Youth in stressed families
   d. Children/Youth at risk for school failure
   e. Children/Youth at risk of experiencing criminal juvenile justice involvement
   f. Overarching concerns is suicide prevention and reduction of stigma and discrimination for those identified as struggling with mental illness.

6. **Workgroup decisions** to be made:
   a. Narrow down priority population recognizing all have needs. In this group, are there one or two groups we want to focus on and is there more data that we need to start making recommendations about programs for prevention and early intervention in those areas.
   b. Making sure we have the appropriate stakeholders involved with this process. Who is not here around the table? Per the state DMH guidelines, we must be sure we have input from all required stakeholder groups. We must be mindful of these groups and make efforts to get information from them so that it is fed into our process. A person may represent more than one stakeholder group.
      i. Based on the data feedback we heard from Applied Survey Research, the major areas of underserved communities is the Latino and LGBT community.
      ii. Education
      iii. Consumers and/or their families
      iv. Providers
      v. Health organizations

      vi.   Social Services

     vii.   Law Enforcement; Input will be gathered by either a focus group or key informant interviews (asking one/two officers to attend one meeting to address our questions).

   viii.   Stakeholders recommended but not required by DMH include representatives from Community Family Resource Centers, Employment, and Media

7. **Review of MHSA PEI values and guiding principles**.  All in attendance stated that they were aligned with these values and principles.

    a.   Transformational programs in action; looking for things that are brand new rather than incremental changes to existing programs that can transform a dilemma or problem.

        i.   Leveraging resources

       ii.   Stigma and discrimination reduction

      iii.   Recognition of early signs

      iv.   Integrated and coordinated systems

       v.   Outcomes and effectiveness

      vi.   Optimal point of investment

     vii.   User friendly plan so that the consumer and family member are comfortable with what we are setting up in non-traditional settings.

**Next meeting**:  Tuesday, July 15, 2008 from 9:30 to 11:30.  Family Services, 104 Walnut Avenue, Santa Cruz

**Mental Health Services Act: Prevention & Early Intervention**
**Work Group: Ages 60+**
**July 15, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Chris Dimaio, Rita Flores, Clay Kempf, Francie Newfield, Laura Orick, Isleen Glatt, Linda Robinson, Kelly Sims, Angie Ledesma, and Karen Dawson.

Meeting was tape-recorded; these notes (taken by Alicia) are a summary of the meeting (not verbatim).

1. Agenda was reviewed. No changes were made.
2. Introductions.
3. **Decision Making**: Ideally the group would reach consensus. Possible problem is that we have a small work group that meets consistently, and non-participating individuals may appear when it is time to vote. Discussed the need for input from others, and need for focus groups, as well as the fact that that some persons may send designees to meetings, if they cannot attend. **Group decision**: when it comes time to vote persons that have participated in at least 50% of the meetings, and attended 3 of the last 5 meetings can vote. Attendance counts if person sent a "designee" in their place.
4. **Stakeholders**. Who is missing? John Gillette? Not sure if Linda called him. There is (or will be) a new geriatric doctor at the county; we will invite him/her. If stakeholder cannot come to meeting consistently, we may invite them to come at least one time. Clay mentioned that he is keeping the Senior Centers and meal sites informed of the PEI process. People felt like this group was representative, and will poll people if additional information is needed. Will hold off on focus groups until we are clear what we want from them.
5. **Resource Material**. DMH gave outlines of various programs. Reaction/Comments? Most persons found that the information was "thin" relative to this population, and that we will either need to "shoe horn" in to one of the programs, or look for other models. DMH has loosened the criteria, but we do still need to evaluate the programs proposed. Jerry is reviewing programs that other Counties are proposing and will share those that he thinks might be useful.
6. **Defining Priority Population**. Discussed the 5 proposed priority populations, and after brief review/discussion narrowed the priority population for this group to Onset of Serious Mental Illness and to Trauma Exposed.
7. **Trauma Exposed**. Brain storm on what this looks like in the 60+ age group: war exposed individuals, ptsd, long history of domestic violence, cultural clash, bereavement and loss (death of friends, spouse, loss of license, loss of functioning), declining health, higher risk of suicide, isolation, "sandwich generation", care giver issues, transitions into long term care/nursing homes/selling home/moving away, no longer "seen"/involved, loss of looks and abilities, loss of bodily functions, being single, loneliness, over medication, and homelessness. Today we are just brainstorming; we'll narrow this down next time.
8. **Onset of Serious Mental Illness**. Escalating health issues (post surgery, loss of hearing, loss of vision), multiple losses, isolation, previous exposure to trauma, exacerbation of

behaviors and/or mental illness, lack of mobility (can lead to depression), addiction to pain medication or sleep medication, drugs/alcohol, dependence turning into addiction, tolerance changes, sleep disturbance, homeless, poor nutrition, moving to long term care, loss of control (not allowed to make decisions), depression and anxiety, retirement (or no longer productive/active), death and dying issues. Older generation is more "shame based" about talking about mental health issues and secrecy. We may come up with program that deals directly with older adults, or one that deals with issues (such as care giver issues) that can be open to persons that are under 60.

9.  **How do we intervene now**? There appears to be good interaction among agencies, if the person is in the system. Many agencies conduct assessments and see what else is needed. **Who are the first responders?** Fire department, police, children, PCPs, taxi drivers, neighbors, emergency responders, home care workers, housing management, beauticians, bankers, DMV, pharmacy, PG & E, maintenance and repair, mail carriers, animal control, in-home support, etc. **Why didn't they report?** Many people don't know what to do. Some people don't know when to report, or don't want to interfere. Others are fearful (of litigation, of the person). Some are in denial. Some people get discouraged because a previous report was not taken seriously. **How does the community know about resources?** Do we have friendly "portals"? Idea of "system navigators was brought up (as it also has in other groups). In Santa Cruz we have an adequate system, but it doesn't work for everybody. Resources are shrinking. There are waiting lists. What do we do about this? Discussed ideas such as buddy system, different models of getting services (neighborhood programs instead of senior centers), "creating community", friendly visitor program, more one on one programs (less groups), cross-generational programs (seniors paired with latch key kids), involve education (e.g. Cabrillo?), etc. Group noted that the senior population is changing. Also want to acknowledge Latino and LGBT groups.

10. **Evaluation of meeting**. Jerry appreciates the energy of this group. Several people agreed. People appreciate Jerry's facilitation, and keeping the group moving. There was both a sense of optimism, and that there are things to be done.

**Next meeting**: Tuesday, July 29, 2008 from 9:30 to 11:30. 18 West Beach Street, Room 6, Watsonville, CA

Attendees: Jerry Solomon (Facilitator), Linda Betts, John Beleutz, Kathleen Johnson, Clay Kempf, Chris DeMaio, Rocio Mendoza, Cecile Mills, Jane Schwicherath, Steve Ruzicka, Kelly Sims, and Ann Pomper

These notes (taken by Linda) are a summary of the meeting (not verbatim).

1. Agenda was reviewed.  No changes were made.
2. Introductions.
3. **Review** of the priority populations for this age group. The discussion then moved on to the pros and cons, and priority, of the different areas that people show up within these populations. They are:
    a. Trauma Exposed Individuals (Symptom)
        i. Isolation, Loneliness (6)
        ii. Caregiver Issues (9)
        iii. Environmental Issues (0)
        iv. Over Medication (2)
        v. Homelessness (2)
        vi. PTSD, to include War exposed (5)
        vii. Military Stressed Families (4)
        viii. Domestic Violence/Abuse (4)
        ix. Bereavement/Loss (7)
        x. Declining Health (0)
        xi. Sandwich Generation, Stressed Families/Kids (4)
        xii. Culture Clash (1)
    b. Onset of Serious Mental Illness (Cause)
        i. Alcohol/Illegal Drugs (9)
        ii. Environmental Transitions (1)
        iii. Sleep Disturbance (0)
        iv. Poor Nutrition (7)
        v. Death & Dying (0)
        vi. Health Related (6)
        vii. Multiple Loss (7)
        viii. Isolation (4)
        ix. Prior Exposure to Trauma (3)
        x. Loss of Functioning (10)
        xi. Medication – Over/Under/Cost (7)
        xii. Suicidality (5)
4. The group discussed situations they had encountered amongst the, "high frequency," populations identified.  The main themes that regularly appeared were caregiver's issues (being seen as needing services/who will take care of the caregiver?), LGBT Seniors (under-counted and underserved, going back into the closet in order to receive services), and seniors experiencing loss of control of their lives.  Overarching themes of, "not being

seen," as one ages and the stigma this age group holds regarding being identified with a mental illness. It was also agreed that the Hispanic community is not well represented. Attempts will be made to have presentations from the LGBT Latino community, the Health Project Center that reaches out to caregivers, the Ombudsman organization, a Nursing Home, and the Seniors Council, at future meetings.

5. Next meeting: Narrow items down, collapse as appropriate. Consider outcomes for each of the high frequency populations.
6. Review of our local resources (a working resource list), to be added to by workgroups.
7. Evaluation of meeting. The group agreed that the level of openness and honesty generated by the facilitator promotes a sound forum in which to participate in these workgroups.

**Next meeting**: Tuesday, August 12, 2008, at Family Services Conference Room, 104 Walnut Avenue, Santa Cruz

<u>**Mental Health Services Act:  Prevention & Early Intervention**</u>
**Work Group: Ages 60+**
**August 12, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Rita Flores, Clay Kempf, Francie Newfield, Laura Orick, Kelly Sims, Angie Ledesma, Jane Schwicherath, Sheri Anselma, Rocio Mendoza, Cecile Mills.

1. Agenda was reviewed.  Cecile wanted to add a letter requesting data; she'll submit PDF to Alicia to be distributed to group.
2. Introductions.
3. **Funding Guidelines**:  The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000.  These amounts are guidelines only; not set in stone.
4. **Priority Populations for all groups** have been identified, as follows:
   a. 0-5: Children & Youth in Stressed Families, and Trauma-Exposed Individuals;
   b. 6-12: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
   c. 13-17: Children & Youth in Stressed Families, and Trauma-Exposed Individuals; Onset of Serious Mental Illness;
   d. 18-25: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
   a. 26-59: Onset of Serious Mental Illness, and Trauma-Exposed Individuals;
   b. 60+: Onset of Serious Mental Illness, and Trauma-Exposed Individuals.
5. **Evening presentations/meetings announced.**
   a. **Tuesday, August 19th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz. We will have a presentation on, "Trauma-Informed Services," by Gabriella Grant (from On Track Program Resources in Sacramento), and Dr. Jerry Solomon will engage the audience to gather input on desired outcomes for Trauma-Exposed individuals.
   b. **Tuesday, August 26th** from 6:30 p.m. to 8:30 p.m. in the large auditorium in the basement of 1080 Emeline Avenue, Santa Cruz.  We will have a presentation on the, "Onset of Mental Illness," by Dr. Charles Johnson, followed by a panel presentation from consumers and family members who have experienced mental illness and will share their stories about what interventions worked (and what did not), as well as their perspectives on desired outcomes.  Presenters include: Carol Williamson and John Wright. Dr. Jerry Solomon will engage the audience to gather their input on desired outcomes.
   c. **Wednesday, September 3rd** from 7:00 p.m. to 8:30 p.m. at the Pajaro Valley Community Health Trust, 85 Nielson Street, Watsonville, CA. Topic: "Stressed Families". Presenter is to be determined.
6. **Program Speaker:  Rita Flores, Family Services Agency**.  Rita spoke about the services at Family Services Agency that are targeted for seniors.  The **Senior Outreach Program** is the oldest of its kind in the State of California.  There are 35 volunteers who go through 40 hours of training (on how to do active listening, on domestic violence, trauma, etc) and have meetings twice monthly that are either group supervision or additional training by various speakers.  Volunteers learn about the specific traumas this age group face (grief, isolation, loss of physical abilities, serious issues with their adult

children, etc). The Senior Outreach Program works because the volunteers are the same age. They serve about 100 people. Don't keep extensive records on clients, but do send out a customer satisfaction survey every year and the feedback/comments are very moving. FSA also has the **Renaissance Program**, which provides mental health counseling to seniors with Medi-Care. Services have to be provided by licensed clinical social workers or licensed psychologists. FSA does not charge a co-pay; FSA gets no reimbursement if there is a "no show". Forty percent of Renaissance clients have had a prior mental health hospitalization. Volunteers who visit persons in nursing homes staff the **"I U Venture" program**. Sometimes they bring others with them, or bring art or other activities to engage the seniors.

7. **Risk factors for "onset" and "trauma."** (At previous meeting, discussed the risk factors for these.) Group rated these as follows:
    a. Onset risk factors
        i. Loss of functioning [10]
        ii. Substance abuse [9]
        iii. Medication over/under/cost [7]
        iv. Poor nutrition [7]
        v. Health issues [6]
        vi. Suicidality [5]
        vii. Isolation [4]
        viii. Prior exposure to trauma [3]
    b. Trauma risk factors
        i. PTSD & military involvement [9]
        ii. Caregivers [9]
        iii. Bereavement/loss [9]
        iv. Isolation/loneliness [6]
        v. Multiple loss [7]
        vi. Domestic violence [4]

8. **Gatekeepers:** Last time group brainstormed the following (and added a few more today): emergency services, primary care providers, taxi drivers, home care workers (IHSS), housing management, beauticians, PG & E, mail carriers, animal control, pharmacies, department of motor vehicles, faith communities, funeral homes, family, neighbors, library, medical equipment vendors.

9. **Priority populations:** Group discussed need to serve persons that are 60+ and are underserved (or maybe resisting services), in residential care, and are monolingual non-English speaking.

10. **Outcomes:** Brain storm on possible outcomes: peer/mentoring/buddy/friendly visitor program (to address loneliness & isolation); nutritional education (discussion about whether this is relevant – meal sites have strict standards, is this a mental health issue? Change in physical can lead to mental issues, poor nutrition may indicate other issues); to train gat keepers in early detection of nutrition problems; to offer appropriate nutrition; increase community wide awareness of nutrition; to offer education and support to caregivers of the elderly; to train gatekeepers regarding LGBT, Latinos, cultural competence; to increase counseling services; to promote the value of services in our community; to decrease the incidence of suicide; to provide transportation (accessibility, isolation); to increase quality of life of caregivers; provide respite for caregivers; provide

education for caregivers; to provide in home services to care givers; to develop meaningful activities for home-bound seniors (calling latch key kids or other home bound seniors); to train homebound seniors (or those in nursing home) to be counselors/buddies; t feel valued and engaged; working with people; breaking fear and creating community safety; decrease in self-stigma; increase social opportunities (library, matinee movie club); early identification of bereaved (skilled nursing facilities/hospice/funeral directors); identification of those who lose their driver's license; physical decline (diabetes, incontinent); identification and outreach to marginalized groups (LGBT & Latinos).

11. **Next Steps**. "Dot" exercise on outcomes; attend evening meetings; review draft resource map (and make additions/edits).

12. **Evaluation of meeting**. One person said she is not "outcome focused" and felt this discussion helped; another said she feels "overwhelmed" because we have identified so much need for so few resources; the final comment was "I didn't feel everyone could be heard; the meeting felt antagonistic at times".

**Next meeting**: Tuesday, August 26, 2008 from 9:30 to 11:30. Family Services Agency, 104 Walnut Avenue, Santa Cruz, Watsonville, CA

**Work Group: Ages 60+**
**August 26, 2008 meeting notes**

Attendees: Jerry Solomon (Facilitator), Angie Ledesma, Cecile Mill, Chris DiMaio, Clay Kempf, Francie Newfield, Ginny Goméz, Guy Grant, John Beleutz, Laura Orick, Linda Robinson, Pam Bartholomew, Sheri Anselmi, and Steve Ruzicka.

1. Agenda was reviewed.
2. Introductions.
3. **Funding Guidelines**: The MHSA Steering Committee decided on funding guidelines for the PEI work groups as follows: 0-25 $840,000 to $1,050,000; 26-59 $210,000 to $350,000; 60+ $140,000-$280,000. These amounts are guidelines only; not set in stone.
4. **Program Speaker: John Beleutz, Del Mar Caregiver Resource Center -** The Del Mar Caregiver Resource Center has been providing services for 18 years, covering Monterey, San Benito, and Santa Cruz Counties. Services are available in Spanish. John spoke about the services that are targeted for caregivers. Traditionally, caregivers do not take care of themselves, the presumption being that the caregiver is competent. Approx. 33,000 caregivers in Santa Cruz County. Women are more affected than men. Outreach through advertising and fairs generally do not reach the target population; clients usually referred through physicians and cancer centers. Services provided are: respite (includes financial assistance and relief for caregivers), family consultation, financial & legal consultation, counseling (short term, 6 sessions), support groups, workshops & training, and online & telephone resources. Currently, there is a wait list for respite care.
5. **Reviewed risk factors for "onset" and "trauma."**
   a. Onset risk factors
      i. Loss of functioning [10]
      ii. Substance abuse [9]
      iii. Medication over/under/cost [7]
      iv. Poor nutrition [7]
      v. Health issues [6]
      vi. Suicidality [5]
      vii. Isolation [4]
      viii. Prior exposure to trauma [3]
   b. Trauma risk factors
      i. PTSD & military involvement [9]
      ii. Caregivers [9]
      iii. Bereavement/loss [9]
      iv. Isolation/loneliness [6]
      v. Multiple loss [7]
      Domestic violence [4]
6. **Gatekeepers:** Emergency services, primary care providers, taxi drivers, home care workers (IHSS), housing management, beauticians, PG & E, mail carriers, animal control, pharmacies, department of motor vehicles, faith communities, funeral homes, family, neighbors, library, and medical equipment vendors.
7. **Priority populations:** Persons that are 60+ and are underserved (or maybe resisting services), in residential care, and are monolingual non-English speaking.

8. **Outcomes:** Onset & Trauma (U=Universal, S=Selective, ST=Strategy). The group refined and clarified some of the outcomes that were identified at the last meeting and added a few more.
    a. To educate gatekeepers to detect and treat bereavement/loss (ST)
    b. To offer support to those losing drivers license (ST)
    c. To identify early and provide counseling to those experiencing physical decline (ST)
    d. To educate system providers about LBGT and Latino concerns (ST)
    e. To ensure that services are accessible: transportation/in-home (U)
    f. To improve the quality of life for caregivers: respite in-home services, telephone/camcorder (S)
    g. To increase involvement: latch key program calling other home-bound, buddies (S)
    h. To increase mental health services to home-bound and in SNF
    i. To promote community wide sense of safety (U)
    j. To create social spaces in "non-traditional" setting, i.e. library
    k. To train gatekeepers in early detection of mental illness
    l. To offer education/support to caregivers of the elderly
    m. To train gatekeepers regarding LGBT issues/cultural competency
    n. To increase counseling services
    o. To promote the values of seniors in our community
    p. To increase awareness of the incidence of suicide
    q. To improve quality of life for 60+ consumers receiving mental health services
    r. To improve 60+ consumers about budgeting for healthy nutritious meals
    s. To offer those in SNF nutritional options for their diet
    t. Improved capacity for exercise
    u. Improve skills of consumer gatekeepers in early detection, etc.
    v. Early identification for those at risk for substance abuse/Rx problems
    w. To improve gatekeepers skills in responding to the needs of those identified with mental illness to make appropriate referrals
    x. To improve awareness of older adult mental health issues/services (U)
    y. To reduce depression/anxiety among targeted groups
    z. To increase and broaden (alternative) services that support mental health
    aa. To offer healing life styles to those over 60
9. **Strategies:** The workgroup started the process of strategizing for outcomes; 24-hour call line, gatekeeper training component to train and educate on how to respond (need a program to refer them to or create the program), increase existing in-home and long-term care facilities peer to peer counseling (social support, target LGBT/Latinos), train gatekeepers: PCP's, medical equipment providers, SVC providers, Community of faith, Housing mgmt, using a hi-intensity format the 1st year and low intensity the 2nd. Include the use of video/community TV, handouts, and information/referral services.

**Next meeting**: Tuesday, Sept. 9, 2008 from 9:30 to 11:30. Family Services Agency, 104 Walnut Avenue, Santa Cruz, Watsonville, CA

Attendees: Jerry Solomon (Facilitator), Alicia Nájera, Linda Betts, David Bianchi, Clay Kempf, Francie Newfield, Laura Orick, Jan Hilkert (for Kelly Sims), Chris DiMaio, Guy Grant, Steve Ruzicka, Sheri Anselmi, John Belutz, Ginny Gomez, Angie Ledesma, Jane Schwicherath, and Linda Robinson.

1. Introductions.
2. **Speakers: Steve Ruzicka and Francie Newfield.**  Steve talked about the **Older Adult Services (OAS) Team** at County Mental Health.  This team serves people 60 years and older that have a serious and persistent mental illness (usually a psychotic disorder) as well as a complex medical condition.  There are two care coordinators for the whole county, service 15 to 20 clients each, 1 therapist, and a recently hired full time psychiatrist.  Primary focus is on servicing clients that have Medi-Cal coverage, but do see some with no insurance.  Care coordinators help clients with housing, discharge plans, social groups, outings, and transportation for medical appointments.  Francie talked about three programs: Veterans' services, Adult Protective Services (APS), and In Home Support Services (IHSS).  **Veterans' Services** on Front Street and in Watsonville; not connected to 41st Avenue Veterans services.  They do not provide mental health services, but do assist in preparing claims and file appeals.  They provide van shuttle to the VA hospital in Palo Alto every day, as well as a bus service on Fridays.  Also provide survivor benefits, burial benefits.  Medical team also comes down to Santa Cruz once a week.  **Adult Protective Service:** there is no mandate at the federal level (and no funding), but there is a state mandate to provide this service (and limited state and county funding).  Investigate abuse of older adults (65 years or older) and/or dependent adults (adults with physical or cognitive disability).  Most common complaint is financial abuse; often occurs with individuals that have dementia.  Referral number is 866-580-4357.  They record referrals, screen calls and have immediate and 10-day response times, depending on the allegations.  If there is a physical risk they call law enforcement.  Some people refuse help from APS, but if multiple referrals come in about a person then APS may go to the Public Guardian to try to get the person conserved (and protected).  Referrals on person in licensed facilities go to the ombudsman/advocacy office.  **In Home Support Services:** serves people of all ages (children, too).  Provide domestic services based on assessment.  Referrals can be made at 454-4101.  Providers are fingerprinted and have background checks.  There is a financial criterion; persons need to be eligible for SSI (medi-cal).  **Questions** about the services raised the issue that services are limited; if client does not meet criteria for OAS there are not many other resources, and even then the OAS services are limited.  Do refer to Family Services Renaissance Program (but their funding is limited and they are required to use only LCSWs and licensed psychologists).  Do refer to primary care providers for issues such as depression, but do not have a psychiatrist in Santa Cruz.
3. Outcomes
    a. To increase access to in-residence professional/peer-to-peer trauma-informed mental health/support services to those over 60.
        i.   Strategy

            1) Offer in-home professional assessment/diagnosis/treatment planning
            2) Offer in-home/in residence peer, as well as professional counseling.
            3) Access to psychiatric evaluation
            4) Access to case management
            5) Offer a buddy program; latchkey kid match, etc.
        ii. Evaluation
            1) Utilization data
            2) Consumer goal achievement measures
            3) Consumer satisfaction measures
            4) Global Assessment of Functioning

b. To provide trauma-informed mental health services to caregivers of those with chronic/catastrophic illness.
        i. Strategy
            1) Offer caregiver-targeted counseling
            2) Provide respite care.
            3) Peer-to-peer support/education groups, as well as professional support
            4) Telephone/cam/internet support (and training)
        ii. Evaluation
            1) Utilization data
            2) Consumer goal achievement measures
            3) Consumer satisfaction measures
            4) Global Assessment of Functioning

c. To promote factors that support resilience and are protective for mental wellness for those 60+.
        i. Strategy
            1) Create social gathering spaces in non-traditional settings, i.e. libraries.
            2) Promote physical activity and awareness regarding healthy nutrition.
            3) Provide referral information to at-risk individuals.
        ii. Evaluation

d. To educate/train targeted gatekeepers to identify those 60+ who are at risk of developing a serious mental illness, suicide and/or are trauma-exposed in order to teach them effective helpful responses.
        i. Strategy
            1) Offer trainings to service providers for detection of early signs and symptoms of mental illness, suicide prevention and trauma involvement with emphasis upon Latino and LGBT consumers.
            2) Have central access point where gatekeepers/consumers can call to find out about services (perhaps adding this on to an existing service)
        ii. Evaluation
            1) Referral data from service agencies.

4. **Priorities:** This group had a vote and decided to recommend "a" as their first priority, and "b" as their second priority. Group discussed how there might be overall training gatekeepers across the lifecycle, and that if so, recommendation "b" could fall under that. If that is the case we want to be sure that we have trainings that speak specifically about older adult issues.
5. **Gatekeepers:** As part of recommendation "b" the group talked about gatekeepers. Gatekeepers include: emergency services, primary care providers, taxi drivers, para-transit, home care workers (IHSS), housing management, beauticians, PG & E, mail carriers, animal control, pharmacies, department of motor vehicles, faith communities, funeral homes, family, neighbors, library, medical equipment vendors, library, meals on wheels drivers, caregivers, long term care facilities, and financial institutions. Group talked about **top tier of gatekeepers** as being: health and social service providers, transit providers, faith based communities, and beauticians.
6. **Group finished its task!!!** Jerry and Alicia thanked everyone for their attendance and participation.
7. **Next Steps**: Jerry and Alicia will be conducting focus groups and key informant interview to get further input (as well as reactions to the recommendations of the workgroups). We will convene the workgroups to view a draft of the recommendations. The MHSA Steering Committee will review the draft of the PEI Plan, and once they approve the draft plan will be posted for 30 days for review and comment by the public. There will also be a Public Hearing (date to be determined), and all workgroup participants are encouraged to come and give their opinion.


**No more meetings scheduled**: the group accomplished their task! **Thank you** everyone for your time, ideas, and participation in the 60+ workgroup!

# Key Informant Interviews

# MHSA PEI
# Key Informant interview
# September 23, 2008

Interviewed: Manny Solano, Deputy Police Chief, Watsonville Police Dept.
Interviewer: Jerry Solomon, PhD

The interview: The interviewer met at Mr. Solano's office on September 23, 2008 for a one-hour interview. The interview was recorded and is summarized below.

## Introduction

Mr. Solano was given a brief explanation of the MHSA PEI process. His importance as a stakeholder to the process was discussed. He was eager to discuss his twenty years of experience with the relationship between law enforcement and mental illness and drug abuse. He noted how frustrating it is for he and his officers because they get involved only after a person is accused of breaking a law. He supports the funding of mental health programs that offer people treatment before they offend.

## Relationship with the Behavioral Health Unit

Mr. Solano stated that when responding to a call the police must assess the situation rapidly to determine if there has been a crime committed, in which case an arrest is made; or if someone is exhibiting signs of mental illness, in which case they are brought to the Behavioral Health Unit for assessment. He reports that there have been good interactions with the BHU during the past few years. The two organizations have worked to coordinate their services and to accommodate to each other's needs.

## Need for officer training

Mr. Solano welcomed the idea of additional training of police officers about mental illness and effective strategies to de-escalate difficult situations that sometimes arise. Currently the Police Department doesn't offer trainings to assist officers to make helpful social service recommendations. He remarked that Alan Lamb, LCSW, at Watsonville Mental Health, helped train his officers in the past and he was very pleased with the results. He believes his volunteers and officers would like to know about available resources they could offer people they encounter that are in distress.

Mr. Solano volunteered that he has thirty recently hired officers needing training and orientation in how to assist the mentally ill. He was very open to a collaborative training model with the mental health community for his officers.

## Outcomes for over 60

Mr. Solano supported the recommended outcomes for this age group. His officers often respond to complaints regarding the elderly who regularly go off their medications. They work closely with Adult Protective Services who assist in making appropriate referrals. "We work as a team."

Gatekeepers he believed to be important include: utility and public works, Retirement Village management staff, para- and metro transit; rescue missions, Salvation Army; food pantries, Meals On Wheels, The Resitar and Plaza Hotel.

## First Break Program

Mr. Solano supported the establishment of a first break program in Santa Cruz County.

It can often be a dangerous situation if police are called into a first break situation. The officer is responsible to assess whether a person needs to be held involuntarily at the BHU for his or her own or for the public's safety. Often there are weapons present.

Mr. Solano spoke with compassion about the situation, "We know the people pretty well because we're a small town, so we try to do the best we can for the individual and their family." The BHU responds well when his officers arrive and the two agencies have well-established protocols. He has not received any complaints from his officers regarding the current system.

## Transition Aged Youth

The group between 18 and 25 years of age is less of an issue for Watsonville compared with the City of Santa Cruz police according to Mr. Solano. Watsonville has fewer homeless in this age group. The homeless in Watsonville tend to be over forty years old. Prostitution is not a common issue in this age group. Occasionally, "some kids find an abandoned home and crash there, but this is not a major problem for the police."

## 6-17

Mr. Solano has dealt with the consequences of drug abuse for most of his career. He has been especially interested in youth drug prevention. He stated that increasing methamphetamine use among youth living in Watsonville is an increasing police concern.

He believes that residential treatment is the most effective intervention for youth and that current services are inadequate to address the needs of Watsonville's youth. "We need more low cost and affordable counseling of all sorts." The best drug treatment results Mr. Solano has seen have been with those attending faith-based programs. The police are often frustrated when outpatient services are offered to people who are on the streets still engaging in problem behaviors.

Mr. Solano agrees that supporting stressed families and youth will assist anti-gang efforts. He felt that it was especially important to involve the churches in Watsonville. He suggested that counseling and follow up services be made available at churches in the area.

One of the Police Department's pressing concerns is how to project drug use and other social forces influencing youth today into the future so that programs can be created to deal with upcoming law enforcement concerns.

Mr. Solano stated that his officers would probably benefit from LGBT focused trainings, but believes that most of the new officers are more sensitive to these issue than in years passed. He was pleased that the first gay pride parade in Watsonville this past summer went well, with no problems reported by the police or the community.

## Closing Quotes

"I think the available mental health services are good, but I need to know more about what is currently being offered in our county."

"Currently there are no officer complaints regarding the mental health system."

"We need assistance in creating projections of how social factors will be influencing law enforcement concerns in the upcoming years."

"Some police forces have added mental health staff to respond to issues more rapidly. We'd welcome having someone like that working with us."

## MHSA PEI
## Key Informant interview
## October 7, 2008

**Interviewer**:  Jerry Solomon, PhD

**Interviewed**:  Dorian Seamster, MD  Health Improvement Partnership of Santa Cruz.

**The interview**:  Ms. Seamster met at the interviewer's office on October 7, 2008 for a one-hour interview.  The interview is summarized below.

### Introduction

Ms. Seamster was given a brief overview of the MHSA PEI recommendations. Her importance as a stakeholder to the process was discussed.  She was eager to share her experience the public health clinics and patients with mental illness and drug abuse.  She stated that at one time there was a mental health provider available in the clinics and that it was a very helpful to the patients.

Ms. Seamster was asked to react to the recommendations from a Primary Care Provider (PCP) perspective.  "The recommendations sound great and it would be wonderful to be able to fund them all.  I'm concerned that there be adequate funding for any one strategy, to really make an impact."

### Priority Need

Ms. Seamster commented on the long recognized need for mental health and social work support for clinic patients.  "One of the top three priorities identified at the Safety Net Clinicians retreat was access to mental health services, particularly for the 0-5 age group."

Ms. Seamster remarked that currently PCP's often perform basic psychological assessments as well as some counseling with many of their patients.  It would be very helpful to have a means of connecting PCP's with other agencies for counseling referrals.  She believed that clinic staff would benefit from meeting regularly with County Mental Health staff in order to create systems for referral and feedback.   She believes it would be helpful to focus on children because many are eligible for County mental health services.

When asked about on-site counseling at the clinics, Ms. Seamster acknowledged the lack of space for these services.  Planned Parenthood organizes their clinic-based services by scheduling their staff when room space is available at the clinic.

### Educating PCPs

"Educating PCP's to assess signs of mental illness and make appropriate referrals is a major priority."  Many PCP find it difficult to keep current with medications that might be used when treating patients with depression.  Therefore, specialty training in the psychopharmacological management of depression and anxiety would be very helpful.

Offering trainings to PCP's is currently being explored by the Health Improvement Partnership (HIP).  It would be very helpful if the PEI education program recommended by the workgroup worked in tandem with HIP's efforts to train all Pediatricians in the county.

## Comments to the Steering Committee

Ms. Seamster wanted to be sure that those making the decisions regarding the recommendations understand the importance of the primary care clinics in detecting the early signs of mental illness in the community at large.

**Her primary concerns are the mental health needs of children and women who present with physical symptoms that often mask or co-occur with mental illness.**

Ms. Seamster was adamant about the Steering Committee making sure that the scarce financial resources that are currently available to us be used wisely and that there be community involvement throughout the process.

# Focus Groups Notes

**MHSA PEI
Youth Focus Group
October 16, 2008**

**Facilitated by:** Alicia Nájera, LCSW, MHSA Coordinator and Linda Betts, MHSA Administrative Assistant.

On October 16, 2008 we met with 7 youth, 4 girls and 3 boys that identify as "LGBT," at the United Way offices in Capitola, CA.   Participants were offered pizza and beverages, and at the end of the session were given $10 voucher cards for their participation.

We provided an overview of MHSA, and specifically described the PEI stakeholder process and the workgroup recommendations, and asked them to provide feedback about their experiences, and their recommendations for PEI.

Each participant shared their views/opinions based on personal experience on what kind of issues they have encountered and what could help LGBT youth.

**Issues/Concerns**:  The primary focus of issues encountered centered on their identity of being "LGBT."  Specifically, they spoke of negative reactions from parents to "coming out," and to being called names or bullied at school.  They also touched on other issues, such as being in foster care ("too many rules"), and medication ("that isn't always the answer; why go there first?").

**Sources of Support**:
➢ Everyone in the group felt that the Gay Straight Alliances (GSA) offer support and a safe place away from home; they wish that every high school and middle school had a GSA.
➢ Peer support is particularly important in coping with the "coming out" process, and peers help "keep one sane".
➢ Ideally, they would go to their parents when bullied, but not all parents are supportive or understand.
➢ One participant shared an experience in an exercise called, "What's in a name?" Provided statistics on suicide and how names can have a negative connotation attached to it and what some of the negative affects they have on people.  She found this particularly helpful.

**Recommendations**:
➢ **Education** about the LGBT youth for parents ("can they be understanding, proud and compassionate?"), and educators. Education through various media venues – things people say and the "real" effect it has on kids/LGBT.
➢ **Counseling services**. They called out counselors needed with training on LGBT issues, peer counselors, counseling for parents of youth who "come out," and counselors to focus on "self esteem" issues for all students.
➢ **Support**, such as having someplace safe to go to after "coming out" to parent/s, particularly if it did not go well.  Having supportive adults in youth's life.

> ➢ **Outreach & Activities**:  Collaboration with other schools; beach bonfires (or other casual settings) where people can gather and share thoughts/ideas.  They also talked about having activities that are *family* friendly, visiting senior's (buddy system) because "they have a lot of knowledge to share," and dances (that are LGBT friendly).

**MHSA PEI**
**Transition Age Youth Focus Group**
**October 20, 2008**

**Facilitated by:** Alicia Nájera, LCSW, MHSA Coordinator and Linda Betts, MHSA Administrative Assistant.

On October 20, 2008 we met with 7 transition age youth (TAY), 3 young women and 4 young men, at the Career Works offices in Watsonville, CA. Participants were offered pizza and beverages, and at the end of the session were given $10 voucher cards for their participation.

We provided an overview of MHSA, specifically described the PEI stakeholder process and the workgroup recommendations, and asked them to provide feedback about their experiences, and their recommendations for PEI.

The participants were a mix of persons receiving services from social services and mental health (entering into foster care as a young child), and persons entering into the mental health system of care as either an adolescent or young adult. Each participant shared their views/opinions based on personal experience on what kind of issues they have encountered. Some provided ideas about what could help youth transitioning from foster care, while others spoke of (mental health and substance use) recovery. All spoke about their experiences with mental health services and their goal towards independence.

A big focus of concern in this focus group was that of lack of communication and not being listened to. All of the participants have had numerous service providers in their lives for many years, and despite the fact that they were involved in different parts of "the system", the concerns they raised resonated with one another.

**The issues and concerns fell into the following categories**:
Lack of Communication/Explanation:
Several people mentioned that the adult service providers did not introduce themselves, much less explain to them what was happening.
  ➢ "No one talked to me or explained what was going on (age 8) as I am being removed from my home to a foster home. Suddenly there are many new adults in my life <u>and</u> a different home. I could have benefited from having a coordinator assigned to me and/or counseling prior to being taken away from home."
  ➢ "I was transported to a hospital without anyone providing information as to what was happening and/or going to happen."
Not being listened to:
Many of the participants felt the service providers (in mental health and social services) made judgments and felt they knew what the participant felt or needed.
  ➢ Tried to communicate to case workers about being abused in foster care, not taken seriously
  ➢ Can tell when being judged – can make mental illness symptoms worse if coordinator comes with preconceived ideas as to what illness I "must" have.

➢ "Sometimes I know I need to be hospitalized, but my (doctor/coordinator) doesn't think so."
➢ "My worker told me she thought I was depressed, but didn't bother asking me if I thought I was."

Hospitalization issues:
Participants in this focus group spoke of the unpleasant experiences they had being hospitalized.
➢ More traumatizing when police/ambulance/fire respond to a suicide attempt.
➢ Released from hospital with too many medications. It took a long time for my doctor to figure out which one(s) to use. (Believes medications are overused in hospitals as a means/objective to keep everyone calm so that staff is safe.)
➢ As a child, during hospitalization, felt totally betrayed and treated like an animal
➢ "I had to stay in the hospital longer waiting for housing to be available."

Access Issues:
Participants shared their stories about problems in accessing services.
➢ Tried to get mental health services, but was denied services.
➢ Difficulty in accessing services from one County to another (Medi-Cal was still coded as being of another County).
➢ "As a child, no tried to help, they just assumed I was energetic with a vivid imagination."

Other service issues:
➢ "It is traumatizing when my counselor/coordinator is changed." Change is hard; want to stay with the same one because a rapport has already been built.
➢ Takes a long time to be approved for SSI
➢ Lack of housing and/or risk of loosing it

**Things that worked well for these participants**:
➢ HPHP asked if I needed help
➢ My best counselor was educated and had personal experience as a foster child – knows how I felt, lived the experience
➢ Appreciate when a doctor works "with" me
➢ My stay at DBHU was ok
➢ Great doctor and coordinator thru Emeline Clinic

**The participants' recommendations fall into the following categories**:
Client Centered Services:
➢ Listen to me!
➢ Listen to children.
➢ If counselor had listened to me, I'd have gotten help sooner.

Advocacy:
➢ An advocate to work with people trying to get in a hospital and see a doctor.
➢ It would help to have an advocate there to explain how the system works and to organize steps to be taken with move (from one County to another).

Additional Services:
➢ More counseling/peer to peer (would keep me out of the hospital, supports me to reach/accomplish goals, keeps me sober).
➢ Provide peer counselor or advocate to accompany client when visiting coordinator (questions on meds can be very confusing and misunderstandings occur).

➢ Offer short-term services to those who start with ACCESS. "I was brushed off because I did not have SSI/Medi-Cal, and feel I was falsely assessed based on appearance and dress (did not look homeless and was keeping myself together). Not until I attempted suicide and was subsequently hospitalized was I assessed and assigned a coordinator/team. This experience may have been avoided with short-term services until I could have been assessed in depth."

Increased skills in service providers:
➢ Would appreciate honesty from counselors – "if they don't know, find out."
➢ Remember that everyone is different (even if diagnosis same).
➢ All providers to have a better understanding of what clients are going through.
➢ Foster children should be told what their rights are. (One person spoke of being forced to attend religious services by her foster parents.)
➢ No judging – be careful of personal appearance and how we move, it's not a mirror of my mental health (have been treated incorrectly based on this).

Alternative Services:
➢ Emphasis on medicating needs to change > use other alternatives (i.e. art therapy). Medications can make symptoms worse.
➢ Too many medications cause side effects and other symptoms.
➢ For children – other options besides hospitalization (treat at home?).

**MHSA PEI**
**Consumer Focus Group**
**Mariposa Wellness Center, Watsonville**
**October 16, 2008**

On October 16, 2008 Alicia Nájera, LCSW, MHSA Coordinator, and Linda Betts, MHSA Administrative Assistant met with consumers in Watsonville, California. Mariposa staff was contacted and they agreed to host and assist in identifying clients who would be willing to participate in a focus group. Participants were offered pizza and beverages, and at the end of the session were given $10 voucher cards for their participation. There were 8 participants in the group of mostly men.

We provided an overview of MHSA, specifically describing the PEI stakeholder process, and asked them to provide feedback about their experiences with the mental health system and their recommendations for PEI.

Each participant shared their views/opinions based on personal experience on what worked best when they became part of the system, what didn't, and what would they tell the MHSA Steering Committee to be mindful of as they make their decisions on programs/strategies.

The common themes that emerged from the group about what did **not** work for them are:
- **Problems with medication**
  - Electric shock and drugs
  - Cost of drugs
  - Allergic reaction to drugs
  - No explanation of what symptoms or side effects of drugs can be expected
  - Medication stopped when released from jail, got sick and ended up in jail, again
- **Problems with hospitalization(s)**
  - Feeling "institutionalized"
  - Threats of hospitalization, particularly when against the patient's will (lack of rights)
  - Housing all mentally ill patients together, (severe cases with the less severe)
  - Symptoms got worse when hospitalized/institutionalized
  - Did not feel safe at DBHU (observed fighting)
- **Lack of Explanation**
  - No one explained what was happening to "me"
  - Few, if any, bilingual staff (at hospital)

The themes that emerged about things that did/do work, or are helpful are:
- **Peer and Social Support**
  - MHCAN – meetings
  - Mariposa – meetings, group gatherings, food, it is a safe place in the community that keeps one from isolation
  - Being around people (not crowds)
  - Parental/family support during the transition period between incarceration and connecting to services
  - Peer counselors

- ➢ Having friends who have gone or are going through the same thing, understanding/empathy
- ➢ Respite
- ▪ **Recovery**
  - ➢ Staying involved with school/work
  - ➢ Once stabilized, working at a job, provides independence (and off SSI)
  - ➢ The system supporting recovery
- ▪ **Medications**
  - ➢ Having the right medication
- ▪ **Professional Support**
  - ➢ Provided (truthful) information by the doctor regarding a new medication (the need to personally understand the illness and why the specific med can work if the directions are followed)
  - ➢ Doctor spending time with client, providing information (education) during each step in the process, developing a good rapport with each other
  - ➢ Specific staff were named as being "very nice <u>and</u> a good influence"

Aside from the items mentioned above that are helpful, the participants recommend the following:
- ➢ Someone (advocate) to help clients with getting a job
- ➢ Mental health screening at an early age (pre-school?)
- ➢ Match mental health coordinators with expertise of a specific illness to the individual that has been diagnosed with it.

## MHSA PEI
## Consumers/Clients** Focus Group
## Mental Health Client Action Network
## October 3, 2008

**Interviewer**: Jerry Solomon, Ph.D.

**Goal**: To obtain feedback from clients about their

- Experiences with the mental health system

- Reactions to the PEl workgroups recommendations

- Comments to the MHSA Steering Committee

**Participants**: MHCAN staff was contacted and they agreed to host and to assist in identifying clients who would be willing to participate in a focus group.
Participants were offered pizza and beverages at the start of the group and were given $10 food vouchers at the end of the group. Ten clients actively participated; equal numbers of men and women. Ages ranged between 25 and 60. All currently use MHCAN's services.

**Format**: The interviewer introduced himself to the group and explained the purpose of the two-hour meeting. He briefly described the PEl workgroup recommendations and then asked each participant to react to the following questions:

- What helped you the most in your recovery from mental illness?

- What aspect( s) of the mental health system was least helpful to you?

- Of the recommendations being made, which might have been most helpful to you and your situation?

- Is there anything that you want to make sure that the MHSA Steering Committee hears from you?

  One participant suggested that it might helpful to structure the feedback allowing each person five minutes to answer the questions. The group agreed to this.

**Discussion**: All participants agreed that it was important to create programs that addressed the needs of the mentally ill as early as possible in the process. All participants supported the recommended PEl programs. Most chose not to prioritize anyone program because they all seemed equally important. Many believed they might have personally benefited if some of the proposed programs had been available to them.

They all agreed how important it is to receive services that are sensitive to their needs. There were varying reports of the effectiveness of providers that many had met along the way. While many benefited from the diagnostic process, most talked

about the importance of being listened to and feeling respected. "I want to explain to others, in my own words, what I am feeling," They all worried about limited financial resources and the recent loss of funding for many local mental health programs.

Many discussed their experiences with the absence of integration of services resulting in multiple treatment plans that were often contradictory. Many lamented the forced changing of helpful providers.

The clients universally gave their support to MHCAN and the safety they all experience there. Many clients felt strongly that it was important to continue programs such as Pioneer House that serve dual diagnosed people.

Conclusions: All agreed resoundingly that it was critically important to their recovery that providers listen and attempt to understand their experiences, rather than just diagnosing them.

For some the most important factor was having rapid access to psychiatric medications and therapy, especially while in jail.

Almost all agreed that change doesn't occur until the person makes a commitment to their own recovery. "Until that happens, nothing can change." But when that does happen those attending the focus wanted to be certain that you knew that. .. "Mental health programs work,"

** When asked, most people who have used the mental health system prefer to be called "clients" rather than "consumers." Most found the label "consumer" unacceptable.

# MHSA PEI
## Parents and Family Members Focus Group
## October 7, 2008

**Interviewer:** Jerry Solomon, PhD
**Goal**: To obtain feedback from family members of the mentally ill about their
- Experiences with the mental health system
- Reactions to the PEI workgroups recommendations
- Comments to the MHSA Steering Committee

**Participants**: The Santa Cruz chapter of NAMI was contacted and agreed to locate participants for the focus group. Six people participated. All were parents of children with serious mental illness. Most began noticing problems with their child's behavior in their teenage years.

**Format**: The interviewer introduced himself and explained the purpose of the two hour focus group. He gave a brief overview of the MHSA process and presented the PEI recommendations prepared by the various workgroups. The remainder of the group focused upon participants' reactions to the following questions:

- Did the PEI recommendations address what hasn't worked and strengthened what has worked in the mental health system?
- Might any of the recommended programs have helped you and your child as s/he entered the system?
- Does any recommendation seem more important to you to be funded than another?
- What do you want the Steering Committee to know that might help them with their decision?

**Discussion**: The participants began their discussion by exploring what hasn't worked for them and/or their child since they've encountered the mental health system.

- Many parents acknowledged multiple missed opportunities throughout the years. A few lamented about not having better knowledge of child behavior and development. "As a parent, I had nothing to compare my child's symptoms to…I assumed they were normal." Others talked about working with mental health providers who did not have experience treating serious mental illness. "Many providers don't want to think a young child is seriously mentally ill."
  Many agreed with one parent's statement, "No pediatrician will diagnose a young child with depression or mental illness."
  One mother talked about not knowing where to get help for her child. It took her nearly two years to locate assistance.
- Ambivalence regarding labeling a child for funding reasons
- Too many treatment plans involving drugs
- A few parents shared experiences of being treated badly, or indifferently by mental health staff. Others talked about how frightened they were when their child was placed in isolation.

**What did work**
- Once a parent located services they were next faced with the challenge of paying for services. Many found effective services for their children within a few hour car ride from Santa Cruz if they had private insurance or had the means to pay out of pocket for services.

- One parent related that she had a positive experience with County Mental Health when her son entered the system.
- All agreed that meeting other parents and receiving peer education and support was invaluable in assisting them cope with their child's mental illness.

**What would you recommend to the Steering Committee?**

Most of those in attendance urged the Steering Committee to consider the following:

1. Provide better access to information regarding the services available locally. All liked the idea of an interactive website for local mental health needs and/or a funded systems navigator position.
2. Create a mental health system similar to the Regional Center, vendoring services and collaborating with other systems (i.e., teleconferencing). This could be especially helpful when offering services to the 0-5 age group where trained providers are less available.
3. There is a need for trained/skilled professionals to work with infants and children. Until that is available a policy should be established that children are automatically referred to Langley Porter for assessment. Ideally, the mental health system would provide time for psychiatrists to be available to consult with primary care providers.
4. All pediatricians should be trained in assessing the signs and symptoms of serious mental illness in infants and youth and be familiar with local services.
5. Treat the families as allies in treatment planning. Offer family members respite.
6. Participants strongly supported the recommendations regarding the educating of parents about mental illness and "the system" by other parents and professionals. They felt a community-wide media campaign promoting mental wellness was an excellent idea.

**Other comments:**

1. Consider occupational therapy as another means of treatment
2. Services offered to youth on-site at the schools is crucial.
3. Research other service models that manage scarce resources. Fore example, might we want to collaborate with the Veterans Administration in working with people with severe trauma?
4. It's important to take into account the comments made during the CSS planning process.

## MHSA PEI
## Focus Group with Spanish Speaking Parents
## October 21, 2008

Facilitator:  Alicia Nájera, LCSW (MHSA Coordinator)

On October 21, 2008, I met with a group of eight (8) parents and family members at the Mariposa Wellness Center in Watsonville, California.  All of them were Spanish-speaking women.  The group was conducted in Spanish.  The participants were offered mixed fruit and beverages, and at the end of the session were given $10 voucher cards for their participation.

I provided an overview of MHSA, specifically described the PEI stakeholder process and the workgroup recommendations, and asked them to provide feedback about their experiences, and their recommendations for PEI.

The participants began by sharing their stories about their loved ones needing mental health services. They are some of the participants of the Mariposa family group that meets weekly, and told me they find the mutual support and education to be extremely helpful.  Here are some of their stories:
- Nephew is dually diagnosed.  School told family he was taking drugs; family had not noticed.  He began hearing voices and is now getting services.  He is under family's care, but he does not want family involved.  Staff tell them, "it is confidential," yet they get charged for services (T-house).  Family was not told anything about what was going on with nephew; they sought out information (in groups).
- "Nervous" child told mom to take him to the doctor.  He was diagnosed with obsessive-compulsive disorder.
- Son was "normal," graduated from high school with good grades.  He began isolating, drinking lots of water, and digging holes in the back yard.  He stopped sleeping and he began talking to himself.  He was jailed for a bike ticket and was referred to County Mental health, but he refused to go.  He was eventually hospitalized.  The hospital did a good job of explaining to the family what was happening.
- Son was aggressive as a child.  He had problems in school and parents noticed he started using drugs.  When he was in his early thirties he began hearing voices, not sleeping, and not eating.  He was hospitalized and stabilized.  He stopped using medications because he felt fine but relapsed.  He is stabilized again and has stopped drinking alcohol.
- Son began isolating and getting depressed when he was a teenager.  Mom looked for help, and he finally accepted services.  He is on medication, but does not do much.  He tends to sleep most of the day and often does not eat.

The participants recommended the following:
- Counseling services to parents about how to deal with a child with mental illness
- Group counseling with a mental health professional facilitating the group
- Mental Health education (for families)
- Counseling at schools
- Activities at no/low cost (there are lots of activities, but families can't afford them)
- Home visits when their child is sick

- For coordinators to have more time to serve their children
- Employment services

**MHSA PEI**
**Focus Group with Seniors**
**October 6, 2008**

Facilitator: Alicia Nájera, LCSW (MHSA Coordinator)

On October 6, 2008, I met with a group of nine (9) seniors at the Senior Center in Watsonville, California. All of them were Spanish-speaking women. The group was conducted in Spanish.

The women were eager to share their life experiences and their thoughts about prevention. They stated *"nosotras sabemos, pero ellos piensan que saben todo";* they "know a lot", even though they often feel dismissed by youth "who think they know everything".

The women shared their thoughts about problems and risks that youth face nowadays. They spoke of youth driving recklessly driving, and taking the car while the parents were away at work. Several echoed in agreement. There was recently a car crash that involved a young driver, and this was fresh on their minds. There was much discussion about youth being "mal educados" and disrespectful. (Note: "mal educados" translates literally to "poorly educated", but is correctly translated to meaning "ill mannered".) In their opinion youth do not obey, do not respect their elders, do not greet you, and talk back. They also noted that there are problems with alcohol/drugs ("vicios") and gangs. "Youth get together to do bad things".

They talked about the problems that families face such as having little support among extended family members, and single women trying to raise their children. "Cuando estan chicos los niños hacen caso a la familia, pero cuando estan grandes le hacen mas caso al ambiente social y a sus amigos." ("When children are little they listen to what their families have more say, but when the children are older they are more influenced by the social ambiance and their friends".)

After discussion the problems, the women came up with the following suggested solutions:
- Offering financial support
- Counseling services at schools
- Having a class for teacher to teach youth manners
- Parent education
- Activities (music, sports, etc) so that youth can be involved in productive (rather than destructive) things
- Seniors can teach a manners class

An over riding theme from this group was the lack of "educación" (manners) and respect among the youth. One woman echoed the sentiment of the group by stating "escuela no tuvimos, pero educación sí". ("We may not have had much schooling, but we were well mannered".)

The group then focused on the needs of seniors. They noted the following concerns among seniors (in general, not just themselves): the lack of company, the need to be heard, the need for attention and affection, acknowledgement from doctors and store personnel, help with hygiene, help with personal care.

The group was eager to suggest solutions and services they would like to see:
- More funding to IHSS
- Counseling
- Activities and distractions
- A senior outreach program in Spanish (and not require the outreach volunteers to be bilingual).
- Transportation to go to North County, for drivers to give the senior time to eat their lunch before coming to take them back, and wished there were more convenient bus stops.
- Group therapy (in Spanish)

The women stated they enjoyed the focus group and were happy they were asked to share their opinions.

**MHSA PEI
Veteran's Focus Group
December 10, 2008**

**Facilitated by**:  Alicia Nájera, LCSW, MHSA Coordinator with notes taken by Linda Betts, MHSA Administrative Assistant.

On December 10, 2008 we met with five Veterans advocate; four were Veterans, two were family members, and two worked with Veterans.  (Some had multiple roles.)  Participants were offered light snacks (fruit platter) and beverages (water and juice).

We provided an overview of MHSA and the components, focusing on the PEI guidelines.  We shared the workgroup recommendations, and asked for feedback and recommendations.

**Issues/Concerns**:
- It should be mandated that everyone put veterans first when planning strategies and services.  Many felt that the Veterans needs are neglected/over looked.
- Most vets will not "present" just anywhere, but will run into trouble with law enforcement first, resulting in a criminal record.  Need to train all first responders (Law Enforcement, EMT's) to recognize and learn how to deal with combat veterans.
- Discussed the fact there is a need to train on posttraumatic stress disorder, and other veterans issues that affect the entire family, their employment and their neighborhood.  The question came up as how will we get medical professionals and law enforcement to attend trainings?
- To reach veterans through services may not be suitable. For the most part, many are not willing to discuss their problem in a clinical or group setting. A social event, where groups can gather over food (for instance), would be more conducive to creating an atmosphere of camaraderie and openness.

**Recommendations**:
- **Training and education** about veterans issues for first responders, expanded to include families and clergy, regarding signs and symptoms of PTSD and mental illness
- **Leverage funds.**  Coordinate with the VA or Dept of Defense for money.  Also bridge services between community service providers and veteran services.  We discussed how recommended services in PEI would not exclude veterans.
- **Intake Forms** should include "are you a veteran?"
- **Alternative sentencing Law**.  This law allows judge discretion to recommend PTSD treatment in place of jail for those "identified" as a combat vet.  Collaborate with system to offer alternatives through mental health services, public and county.
- **Outreach.**  Where veteran's make the most impact is the place to reach out to them (a broader issue and the impact on the family). The most effective way of reaching out to veterans is through socialization. The Wellness centers provide this and could be developed with Vets in mind.
- **Use of VA Memorial Building**.  The County owns the building on Front Street. Some brainstorming on how to use (and support) the building: establish an office there for downtown outreach workers; collaborate with entities that rent space a provision that

enables (fixed number) veterans to participate free of charge (for instance, rock concerts would give away 10 tickets to vets).

➢ **Services to Veterans and their families**. Treatment for combat veterans should include immediate family members.

**Final Thoughts:**

➢ **Veterans should be a focus in PEI.** While it is understood that Veterans and their families will not be excluded from any PEI program, it was strongly felt by everyone in the group that there should be a particular program that specifically focuses on Veterans.

➢ **Wellness Center.** Some members of the group like the ideas of the Wellness Center, such as exists in the mental health arena. There are some wellness activities, but could build on this. Part of the attraction is to draw out veterans that are isolated and not getting (needed) services. "The social aspect is at the heart of prevention and early intervention, and it's a good way to get people to relax and talk."

➢ **Trainings.** Many in our community need to have a better understanding of issues that veterans and their families face. The facilitator mentioned that the Workforce Education Training Academy should be able to include some training on veterans' issues.

➢ **Alternative Sentence Law.** Would like to see all law enforcement trained. Facilitator mentioned that that might not be feasible under PEI, but that if the Training Academy has trainings they could be invited. Also discussed how mental health jail staff would be good targets for training on veterans' issues, and the Alternative Sentence Law in particular.

➢ **"System of Care" for Veterans.** Everyone in our community that provides services for veterans should collaborate and coordinate. We are already working on how to improve this.

➢ **Advocate for Veterans.** There needs to be an advocate position between County services and the VA

# Final Workgroup Meeting

"Cross walk" document comparing Workgroup recommendations
and County's proposed projects

| Recommendations | Proposed Projects |
|---|---|
| **Early Childhood (0-5):**<br>**Strategy #A:** To provide screening by pediatricians (and others) for bio-psycho-social and emotional health and development of children ranging ages 0 to 5.<br><br>**Strategy #B:** Provide parent education for families with children ages 0 to 5.<br><br>**Strategy #C:** To provide therapeutic intervention for children ages 0 to 5, with a focus on 0 to 3 year olds.<br><br>**Strategy #D:** To provide education to gatekeepers on physical, social, emotional, health, and development of children (ages 0 to 5), with targeted training to designated providers on screening assessment and treatment of young children.<br><br>**Children (6-17):**<br>**Strategy #E:** To provide on site services at non-clinical settings (i.e., school based, Family Resource Centers) to screen for and provide peer and professional support/counseling<br>   ▪ Providers will be trained to provide "trauma informed" services<br><br>**Strategy #F:** Provide skill-based training to parents at non-clinical venues (i.e., Family Resource Centers, school-based programs).<br>   ▪ Parent/child non-violent communication classes; understanding age-appropriate behavior; effects of psychiatric medication in children.<br>   ▪ Support and resource access | **Project #1: Early Intervention Services for Children**<br>Priority populations: children and youth from stressed families, onset of mental illness, and trauma exposed children and their families. Focus: families needing parental/supervision skills, are affected by substance use/abuse, and/or are exposed to violence, abuse and /or neglect. Goal: to decrease the negative impact of these factors. This program also addresses disparities in access to services by prioritizing the Latino and LGBT population.<br><br>**Strategy #1: Early Childhood Screening and Early Intervention** (A, C, D, E, F and G)<br>Addresses the unique needs of early childhood.<br>   ➢ New assessment center for children aged 0-3. Includes weekly site-based assessments, as well as field-based services. This is a multi-disciplinary project, in coordination with Dominican Hospital, First Five, and Child Welfare. Referrals will come from Child Welfare. Plan to expand services to children in county and contract mental health programs, and extend age range to 0-5.<br>   ➢ Increase mental health screening, assessment, and consultation at child care settings (including Family child Care Homes, Pre-school, child care centers, as well as "informal" care providers).<br><br>**Strategy #2: County-Wide Parent Education & Support** (B, D, E, F)<br>Goal is to implement evidenced-based practice to provide increased outreach, engagement, and support of stressed families throughout Santa Cruz County. The County is engaged in a community learning collaborative reviewing new and existing practices. Plan is to work with key early childhood stakeholders to finalize selection of an evidence based practice, utilize request for proposal for selection of contractor(s), do initial provider trainings, and implement initial phases over 2 year start up period. |

| Recommendations | Proposed Projects |
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| (Continued from previous page)<br><br>**Strategy #G:** To educate/train targeted gatekeepers (i.e. parents/family, peers/youth, Primary Care Providers, Teachers/School personnel, Social Service Providers, Activities – i.e. coaches, Boys and Girls Club, Little League) to identify youth exposed to trauma (i.e. violence, child sexual abuse, homophobia, racism) and/or at risk of suicide and/or a serious mental illness and how to effectively assist them.<br>▪ Offer training/educational events at non-clinic based venues (i.e., FRCs, schools).<br>▪ Offer training and educational events through venues (i.e. Training Academy) and other venues.<br>Train all health care providers serving targeted groups to identify early signs and symptoms of mental illness, suicide risk, and/or trauma exposure.  Offer service providers ways to respond to youth and their families.<br><br>**Strategy #H:** Provide rapid access to school-based and other counseling support services for those being bullied and bullying.<br><br>**Strategy #I:** Identify and support a school mental health advocate from existing staff within each school to assist in early detection and prevention of suicide and serious mental illness by offering emotional/physical support to targeted youth. | **Project #1:  Early Intervention Services for Children** (continued from previous page)<br><br>**Strategy #3: Culture Specific Parent Education & Support** (B, F)<br>County to provide culturally specific, trauma-informed, and oriented towards suicide prevention, with priority given to youth and families that are Latino, LGBT or other marginalized communities. We have chosen Cara y Corazón and Jóven Noble (models that have been used by the Alcohol and Drug) based on the positive experience to date and relevance and effectiveness for the special needs of Latino families. Cara y Corazón is a culturally based family strengthening and community mobilization approach that assists parents and other members of the extended family to raise and educate their children from a positive bicultural base. Jóven Noble is a youth leadership development program.<br><br>**Strategy #4:  School-based Prevention & Early Intervention** (E, H and I)<br>Focus will be on youth in stressed families, trauma-exposed individuals, and onset of serious mental illness (as well as youth at risk of school failure and risk of juvenile justice involvement). County will conduct a request for proposal to identify appropriate contractor(s) that will build on lessons learned from recent school-linked activities, integrate with related prevention & early intervention, and demonstrate ability to effectively reach out and engage Latino students/families, and LGBT. |

| Recommendations | Proposed Projects |
|---|---|
| **Transition Age Youth:**<br><br>**Strategy #J:** To offer low cost/free client-centered mental health services to transition age youth that are culturally sensitive, trauma-informed, and promote an independent and productive life for TAY at risk of onset of mental illness, especially targeting the LGBT and Latino youth.<br>■ (Early intervention) Counseling services to TAY with special emphasis in foster care and alcohol/drug programs<br>■ Assessment of psychosocial and drug/alcohol treatment needs with treatment planning/consumer goal statements<br>■ Outreach programs to LGBT and Latino youth<br>■ Peer-to-peer programs<br>■ Advocacy<br>■ Paid stipends and work crew options<br><br>**Strategy #K:** To offer mental health/support services to family members (or other support system) of targeted TAY.<br>■ Involve the family/support system early in treatment planning and offer them support services<br>■ Offer peer-to-peer support groups<br>■ Educate family about mental illness and the services available to the consumer and family<br><br>**Strategy #L:** To provide training, technical assistance, and consultation to gatekeepers serving targeted youth to help them identify youth at risk of suicidal behavior or serious mental illness, and how to effectively assist them in a culturally sensitive manner. | **Project #2: Early Onset Intervention Services for Transition Age Youth & Adults**<br>Priority populations: transition age youth and adults who are trauma exposed and are experiencing (or at risk of experiencing) the onset of serious mental illness. Focus: Persons seen as being most at risk: substance abuse/use; military exposure; family history of suicide and/or mental illness; and abuse (physical, sexual and/or emotional). Goals: To provide prevention and early intervention to persons affected, and their families. To coordinate the delivery of peer and professional support/counseling evidence-based client-centered services in traditional and non-traditional settings. This project also addresses disparities in access to services.<br><br>**Strategy #1: Identification of Signs & Early Symptoms of Mental Disorders with Family Members, Professionals, and Community Entry Points throughout the County (L, N)**<br>Promote early identification of, and intervention with, persons age 18 to 59 who are at-risk of serious mental illness or suicide by training and supporting targeted community entry points and professionals.<br><br>Phase 1: Outreach Community Entry Points (e.g. Primary Care, Alcohol & Drug Programs, etc.), Professionals, and Family members to identify and intervene with persons at-risk of serious mental illness.<br><br>Phase 2: Conduct training with professionals, family members, and community entry points on how to identify early signs of persons at-risk of serious mental illness, including suicide and/or first break psychosis. Also inform audiences on how and where to refer for mental health services; how to use recovery oriented client-centered services; and how to manage symptoms in various settings. |

| Recommendations | Proposed Projects |
|---|---|
| (continued from previous page)<br><br>**First Break:**<br>**Strategy #M:** To offer evidence-based treatment (EPPIC?) to treat the primary signs and symptoms of psychotic disorders and provide on-going recovery services for up to two years. This program shall:<br>   ▪ Engage family members early in the treatment process and enlist them as allies in assisting the consumer.<br>   ▪ Offer a peer-to-peer program for exposure to persons that are successful in their recovery and can serve as mental health advocates for consumers.<br>   ▪ Offer a program that enhances resilience and protective factors for those identified as "at risk" for developing serious mental illness.<br><br>**Strategy #N:** Train targeted gatekeepers in early signs and symptoms of mental illness and the warning signs for suicidal behavior. Train targeted gatekeepers on strategies to effectively assist individuals at risk of serious mental illness or suicidal behavior, including how to make appropriate and helpful referrals. | **Project #2: Early Onset Intervention Services for Transition Age Youth & Adults** (continued from previous page)<br><br>**Strategy #2: Early Onset Intervention Services for Individuals and Family Members** (J, K, M) Provide early intervention services to transition age youth & adults who are at risk of onset of mental illness or risk of suicide.<br><br>In conjunction with the training and consultation services described in strategy #1 the County will provide client-centered clinical services (receiving referrals from professionals, family members, and community entry points), consultation, assessments, and short-term mental health services; referral to psychiatrist and/or longer-term services, as needed; and counseling and support to family members. Peer advocates will provide counseling, support, and network with professional and natural supporters. Employment Services will offer assistance in finding jobs or paid stipends for work crew options. Staff will serve as "system navigators" in order to assure continuity of care.<br><br>County will also contract with Suicide Prevention (which will serve persons across the lifespan) see *page 181.*<br><br>**Strategy #3: Monthly TAY Roundtable** (J, K) County will coordinate the delivery of peer and professional services to transition age youth and their families. Providers to include children and adult mental health homeless persons health project, counselors/coordinators, outreach workers, homeless garden project, County Office of Education, CASA, employment services, and others as appropriate. The Monthly community meeting will enable care providers to be aware of resources and enhance the coordination of services; this is an activity requested by TAY providers. There will be no cost associated with this strategy, other than staff time.<br><br>**Strategy #4: Veterans Services** (*See page181*). |

| Recommendations | Proposed Projects |
|---|---|
| **Older Adults**: <br> **Proposed Project**: This program addresses persons age 60 and older experiencing onset of serious mental illness, trauma-exposed individuals, and disparities in access to services. <br><br> **Strategy #O: To provide direct mental health services to older adults in Santa Cruz County** <br> Offer in-home professional assessment/diagnosis/treatment planning <br> Offer in-home/in residence peer, as well as professional counseling <br> Access to psychiatric evaluation <br> Access to case management <br><br> **Strategy #P: To provide education to gatekeepers about the early signs and symptoms of mental illness in the older adult population.** <br> Offer trainings to service providers for detection of early signs and symptoms of mental illness, suicide prevention and trauma involvement with emphasis upon Latino and LGBT consumers. <br> Have central access point where gatekeepers/consumers can call to find out about services (perhaps adding this on to an existing service) | **Project #3: Early Intervention for Older Adults** <br> Priority populations: Persons age 60 and older experiencing onset of serious mental illness, trauma-exposed individuals, and disparities in access to services. Focus: Address onset of mental illness risk factors that include loss of functioning, substance abuse, medication issues, poor nutrition, multiple losses, health issues, suicidality isolation, and prior exposure to trauma. Trauma exposed individuals include persons suffering from PTSD and military involvement, bereavement & loss, isolation/loneliness, and domestic violence. Goal: To provide prevention and early intervention to persons affected, and their caretakers. This project addresses issue of stigma, isolation, and lack of transportation by putting an emphasis on providing services in the home. <br><br> **Strategy #1: Field Based Mental Health Training and Assessment Services** (O, P) <br> County to hire an Occupational Therapist (OT) to provide outreach, assessments, and short-term case management to older adults where they reside. Referrals may come from a variety of senior service programs, family members, and others. The OT will link with psychiatric services, case management services, therapy services, and/or linkage to peer support services, as appropriate. <br><br> We will also train staff (at key senior organizations), professionals, family members, and others that come in contact with older adults to better recognize signs of depression and other mental illness, and help seniors connect to services. <br><br> County to contract with community-based agency for early intervention counseling services (provided) where older adults reside. |

| Recommendations | Proposed Projects |
|---|---|
| (see previous page) | **Project #3:  Early Intervention for Older Adults** (continued from previous page)<br><br>**Strategy #2: Senior Outreach through Peer Companions** (O)<br>County will contract with a community-based agency that can build on existing seniors programs to provide in-home peer counseling services. The peers will be trained (as described above) to recognize signs and symptoms of distress, and will provide companionship and light respite work for elderly.  Services will be mobile and short-term (up to one year). Peers will work closely with the OT for support, supervision, and referrals. Recruitment of peer companions will include Spanish-speaking capacity.<br><br>**Strategy #3:  Warm line** (P)<br>Provides quick telephone screening and referrals for persons seeking services for older adults. Senior Network Services, the central coast resource hub for all senior services in Santa Cruz County, will add a half-time position to existing services to increase capacity to respond quickly to community needs.  Services will be enhanced so that Senior Network Services is able to take an anticipated increase in volume of calls, make appropriate referrals, and can be better targeted to serve Seniors with early onset of mental health condition. The OT will provide consultation to Senior Network staff. |

**Common Themes Across Work Groups**
Workgroups were structured to focus on issues of specific age groups. While there are specific strategies in prevention and early intervention, depending on the age group targeted, it was interesting to see the following themes:
- Need for training, education, and consultation services about signs and symptoms of mental illness.
- Need for information about community resources.
- Need for information about signs and symptoms of suicide risk.
- Need for services affecting Veterans and their families.
- Need to evaluate the effectiveness of the services provided.

**Prevention Services Across the Life Span (to be incorporated in the Projects listed above)**
**1. Education, Training and Consultation**
Target audiences: Primary Care Providers, Community Entry Points, family members, and peer supports.
Goals of this strategy:
1. To increase awareness of the signs and symptoms of mental illness across the life span (early childhood, youth, transition age youth, adults, and older adults).
2. To increase awareness of the signs and symptoms of mental illness across diverse populations (Veterans, Latinos, LGBT, and the families of these groups).
3. To increase the knowledge of community resources available.

County PEI staff along with existing Workforce Education Training Academy will provide these educational services.

**2. Suicide Prevention**
County to contract for, "Suicide Awareness for Everyone (SAFE):"
➤ To raise community awareness
➤ Educational presentations for youth
➤ Training for "gatekeepers" (community entry points)
➤ Information presentations
➤ Support for adults coping with difficulties, including loss of loved one
➤ 24 hour crisis line

**3. Veterans and Their Families**
In order to strengthen linkages and coordination between County Mental Health and local Veterans services the County will contract a Veterans Advocate. In addition this advocate will help ensure the inclusion of Vets and their families in other relevant PEI services (including, but not limited to, parenting education, school based prevention services, field based services for TAY, Adults and Older Adults).

This person will be responsible for knowing the various Veteran resources in the community, provide and/or support wellness activities, and assure the County is compliant with AB 3083 (linkages between County and Veterans agencies).

The County will also include education and training on Veterans issues in the Workforce Education Training Academy. This may include issues such as post-traumatic stress, effects on children and spouses, issues of isolation, and/or issues of adjusting post-war experience.

**4. Evaluation**
The County proposes to focus a special evaluation of Cara y Corazón. Additionally, all programs provided at the County or by contract agencies will be expected to take part in overall evaluation activities using a Participatory Action Research (PAR) model. This approach is intended to provide real

time feedback to improve program performance and to guide decisions about the accountability and "value added" by these new services, as future funding plans are considered.
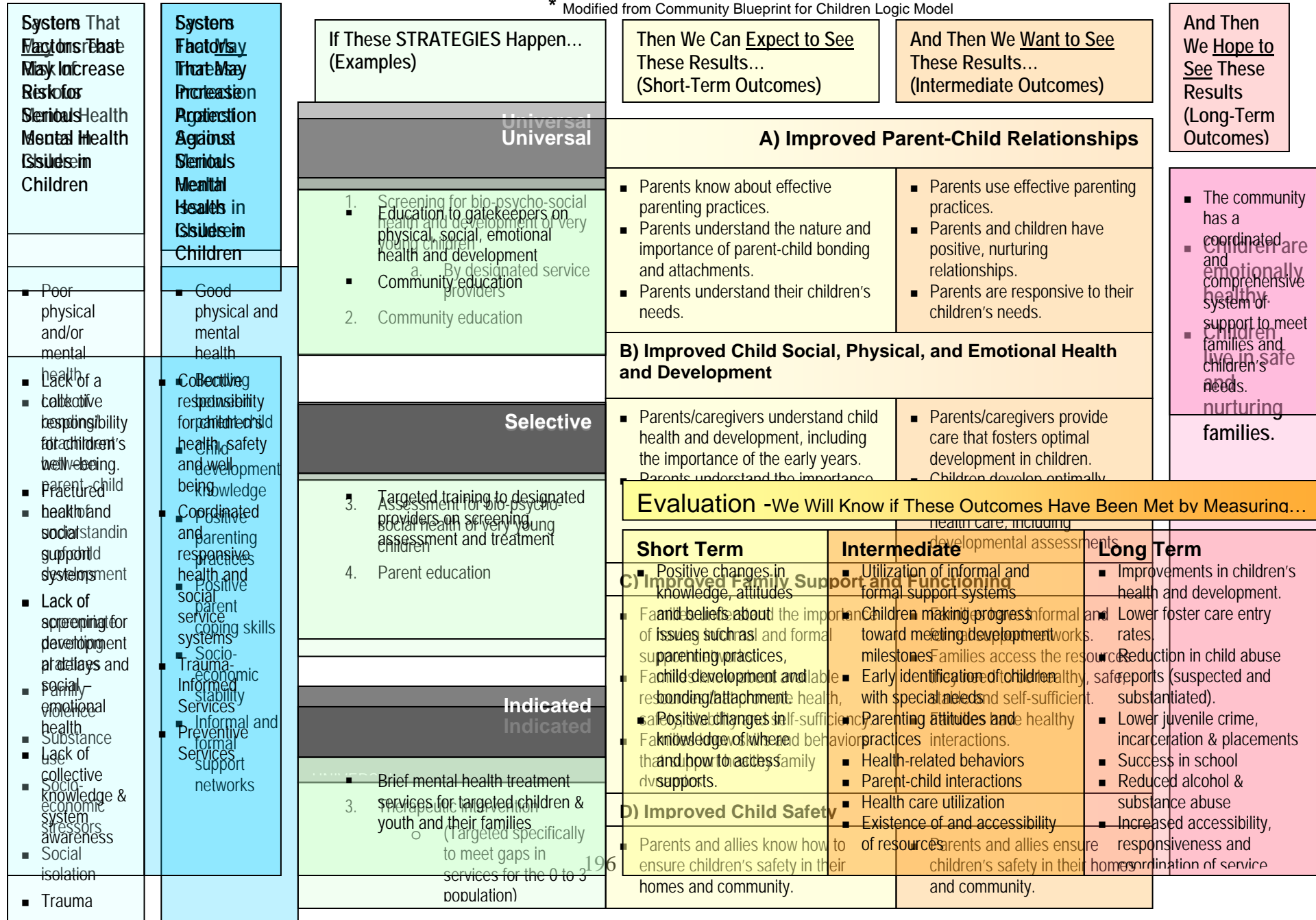
*Note: The MHSA Steering Committee prefers not to use the term "gatekeeper" as that implies keeping people out. You will see the term "community entry point" instead.*

# MHSA Prevention and Early Intervention for Children/Youth Logic Model
## Individual & Family Levels
*\* Modified from Community Blueprint for Children Logic Model*

| Systems/Factors That May Increase Risk for Serious Mental Health Issues in Children | Systems/Factors That May Increase Protection Against Serious Mental Health Issues in Children | If These STRATEGIES Happen… (Examples) | Then We Can Expect to See These Results… (Short-Term Outcomes) | And Then We Want to See These Results… (Intermediate Outcomes) | And Then We Hope to See These Results (Long-Term Outcomes) |
|---|---|---|---|---|---|

**Universal**

1. Screening for bio-psycho-social health and development of very young children
   a. By designated service providers
2. Community education

**A) Improved Parent-Child Relationships**

- Parents know about effective parenting practices.
- Parents understand the nature and importance of parent-child bonding and attachments.
- Parents understand their children's needs.

- Parents use effective parenting practices.
- Parents and children have positive, nurturing relationships.
- Parents are responsive to their children's needs.

**B) Improved Child Social, Physical, and Emotional Health and Development**

**Selective**

3. Assessment for bio-psycho-social health of very young children
4. Parent education

- Parents/caregivers understand child health and development, including the importance of the early years.

- Parents/caregivers provide care that fosters optimal development in children.

**Evaluation** - We Will Know if These Outcomes Have Been Met by Measuring…

| Short Term | Intermediate | Long Term |
|---|---|---|
| Positive changes in knowledge, attitudes and beliefs about the importance of issues such as parenting practices, child development and bonding/attachment. | Utilization of informal and formal support systems | Improvements in children's health and development. |
| Positive changes in knowledge of where and how to access family supports. | Children making progress toward meeting developmental milestones | Lower foster care entry rates. |
| | Early identification of children with special needs | Reduction in child abuse reports (suspected and substantiated). |
| | Parenting attitudes and practices | Lower juvenile crime, incarceration & placements |
| | Health-related behaviors | Success in school |
| | Parent-child interactions | Reduced alcohol & substance abuse |
| | Health care utilization | Increased accessibility, responsiveness and coordination of service |
| | Existence of and accessibility of resources | |

**Indicated**

3. Brief mental health treatment services for targeted children & youth and their families
   o (Targeted specifically to meet gaps in services for the 0 to 3 population)

**C) Improved Family Support and Functioning**

**D) Improved Child Safety**

Parents and allies know how to ensure children's safety in their homes and community.

Parents and allies ensure children's safety in their homes and community.

- The community has a coordinated and comprehensive system of support to meet families and children's needs.
- Children are emotionally healthy.
- Children live in safe and nurturing families.

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**MHSA Prevention and Early Intervention for Children/Youth Logic Model**
System Level
**\*** Modified from Community Blueprint for Children Logic Model

| If These STRATEGIES Happen… (Examples) | Then We Can Expect to See These Results… (Short-Term Outcomes) | And Then We Want to See These Results… (Intermediate Outcomes) | And Then We Hope to See These Results (Long-Term Outcomes) |
| --- | --- | --- | --- |

**E. Improved System Capacity and Collaboration**

| | |
| --- | --- |
| ■ Gate keepers have increased knowledge of how to educate parents on how to support the social emotional health of young children<br>■ Health Care providers know how to screen children for socio-emotional issues and where to refer children for assessment.<br>■ Providers of services gain knowledge on how to access new funding.<br>■ Increased Peer-to-peer education/support for parents. | ■ Gate keepers educate parents on how to support the social emotional health of young children<br>■ Children are screened and referred for assessment (when needed).<br>■ Providers of services have the capacity to leverage needed funds. |